Health Strategy for the Nineties: *Managing Better Health*

Summary, November, 1990

Nova Scotia
Department of Health

91-01260/

HEALTH STRATEGY FOR THE NINETIES: Managing Better Health, describes in detail how the Government of Nova Scotia, in partnership with health care professionals and the public, intends to improve Nova Scotia's health system. This Summary provides a concise statement of the new Health Strategy.

Copies of

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Managing Better Health

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The Nova Scotia Government Book Store
1700 Granville Street
One Government Place
P.O. Box 637
Halifax, Nova Scotia
B3J 2T3
Telephone: (902) 424-7580

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TABLE OF CONTENTS

INTRODUCTION 1

PART I IMPROVED PLANNING AND MANAGEMENT OF HEALTH SERVICES 5

Introduction 5
Provincial Health Council 5
Regional Health Agencies 6
Reorganization of the Department of Health 7
Coordination Among Government Departments 8

PART II THE HEALTH PROFESSIONS 9

Introduction 9
Nurses 9
Physicians 9
Associate Health Professions 11

PART III REVITALIZED HEALTH SERVICES 13

Health Care Priorities 13
Nova Scotians' Health Status 13
Health Care Spending 13
Health Services:
1. Primary Health Care 15
2. Health Promotion and Disease Prevention 16
3. Treatment Services 16
4. Continuing Care 17
5. Mental Health Services 17
6. Drug Dependency Programmes 18
7. Ambulances 18
8. Pharmacare 18

APPENDIX 19

List of Policy and Programme Initiatives Contained in **HEALTH STRATEGY FOR THE NINETIES: Managing Better Health** 19

INTRODUCTION

Why a New Health Strategy?

Nova Scotians are proud of the accomplishments of their health care system. More than 20 years ago, Nova Scotia introduced publicly-funded insurance programmes for hospital and medical services. Since then, our province's health care system has grown to include a province-wide network of hospital facilities.

Our health care system has concentrated to date on providing all Nova Scotians with medical treatment when they become ill. For example, Nova Scotia now ranks third among all provinces in per capita expenditures on physicians' services.

The health care system has paid less attention, however, to programmes that **prevent illness and promote good health**. Health promotion enables people to increase control over, and improve, their health. Examples of such programmes include immunizations (e.g. against childhood diseases and influenza), prenatal classes for pregnant women and educating seniors about the side-effects of medications.

Nova Scotia's health care system is a top priority of the Government of Nova Scotia. The Government is committed to increasing the effectiveness of our health system and to improving the health of Nova Scotians.

The Government believes the health system must adapt to the changing health needs of Nova Scotians — for example, the needs of the elderly as they account for an increasing share of the total population. The Province of Nova Scotia also wants to ensure stronger **community involvement** so that the public has a greater say in the health system.

The Government of Nova Scotia also will work to see the health care system **managed more effectively**. This is the best way to ensure that Nova Scotians will continue to have access to the top-quality health care they are entitled to, at a cost they, as taxpayers, can afford. Those responsible for managing health services must be prepared to account for taxpayers' dollars, and show that the funds are being well spent.

The Government will, in cooperation with health care professionals and the public, work to maintain and improve the quality of health services, while slowing the growth of health care costs. To achieve this we must:

- do more to prevent disease and promote health;
- manage financial and human resources more carefully, to get better results for the money spent.

The existing health care system does an excellent job of treating illness. The Government's new **HEALTH STRATEGY FOR THE NINETIES** will build on the strengths of the existing system, and improve it.

The Royal Commission on Health Care and Government's Response

The Nova Scotia Royal Commission on Health Care presented its Report to Government and the public in December 1989. The Report recommended that the Government of Nova Scotia set policies aimed at improving Nova Scotians' health and increasing the health care system's cost-efficiency. The Royal Commission also recommended that the Government step up efforts to promote healthy lifestyles and prevent disease.

The Government of Nova Scotia accepts the overall approach recommended in the Royal Commission Report. Specifically, the Government's new Health Strategy is based on the following five inter-connected principles:

1. Promoting Health, Preventing Disease

Promoting health and preventing disease is vital for improving the health status of Nova Scotians and focuses on individuals and communities. Several programmes are already in place. Government has begun a pilot project to screen women for breast cancer so that it is detected early, when treatment is most effective. A Community Health Promotion Fund has also been established to help finance community-managed projects that promote good health. Government has promoted good health for its own employees by adopting a smoke-free workplace policy. Under the new Health Strategy, successful programmes will be expanded and additional programmes will be developed.

2. Improved Management of Financial and Human Resources

Efforts have already begun to eliminate wasteful duplication and provide better service to the public. For example, community hospitals and nursing homes in several communities have saved money by cooperating to operate common laundry and kitchen facilities. These and other efforts to improve management in the health care system will be increased.

3. Increased Public Involvement

The goal of the Government is to give citizens a more active role in setting priorities for the province's health system and deciding how our limited health care resources should be used to best meet our health needs. The Provincial Health Council has been established to enable greater public participation in health planning and priorities.

4. Regional Planning

Health services will be planned on a regional basis, so that services can be adapted to meet the unique needs and priorities of each of the province's regions — as defined by residents of those regions. Six Regional Health Agencies will be established to advise the Minister of Health on regional health services.

5. Improving Community Access to Health Care

When people require treatment for an illness, treatment services will be provided as much as possible in community settings, such as community health centres, outpatient clinics and patients' homes.

The Summary is organized as follows:

Part I describes mechanisms for greater public involvement and improved health services management: these include the Provincial Health Council, new Regional Health Agencies, a reorganized Department of Health, and new measures to coordinate the work of all provincial government departments whose actions have an impact on health.

Part II focuses on the health professions — nurses, doctors and associate health professionals — and strategies for better management of human resources in the health sector.

Part III describes the measures Government will be taking to improve community health programmes, hospitals, Pharmacare and other health services.

Following Part III is an Appendix which lists all of the policy and programme initiatives contained in the full Strategy document.

PART I
IMPROVED PLANNING AND MANAGEMENT OF HEALTH SERVICES

INTRODUCTION

The new Health Strategy includes several mechanisms to improve the planning and management of health services, especially through increased public participation. The ultimate goal is to have the health care system respond better to people's needs and thus provide good health for all Nova Scotians.

The new mechanisms include:

- the Provincial Health Council;
- Regional Health Agencies covering all regions of the province;
- a reorganized Department of Health; and
- measures to improve coordination among the provincial government departments whose policies and programmes affect our health.

Provincial Health Council

The Provincial Health Council is a way for the public to have a say in health policy and planning at the provincial level. The Health Council will make recommendations to the provincial Cabinet, through the Minister of Health. It will monitor all aspects of Nova Scotia's health system and provide ongoing advice to Government on ways to improve the system. A key task of the Provincial Health Council will be to recommend Health Goals for the province. The Health Council will report to the public every year in a published **Annual Report** which will review the province's progress in achieving those Health Goals.

The Provincial Health Council will have a maximum of 12 voting members, who will serve three-year terms. Members will serve as non-paid volunteers and will be chosen for their demonstrated commitment, competence and leadership.

The Health Council will be formally independent of Government. It will obtain information and opinions from the general public and from a broad range of groups in the health field. The Department of Health will support the work of the Health Council by supplying statistics and research when called upon to do so.

Regional Health Agencies

Under the new **HEALTH STRATEGY FOR THE NINETIES**, Government will take steps to give communities and regions a stronger voice in health planning. A first step will be the establishment of Regional Health Agencies in all regions of the province, whose role will be to provide the Minister of Health with advice on the unique health needs and priorities of each region.

Each Regional Health Agency will have a Board, appointed by the Minister of Health following a public call for nominations. The Boards will have a balance of community representatives and health care providers. Members of Regional Health Agency boards will serve as volunteers.

Six health regions will be established — *see Figures 1 and 2.*

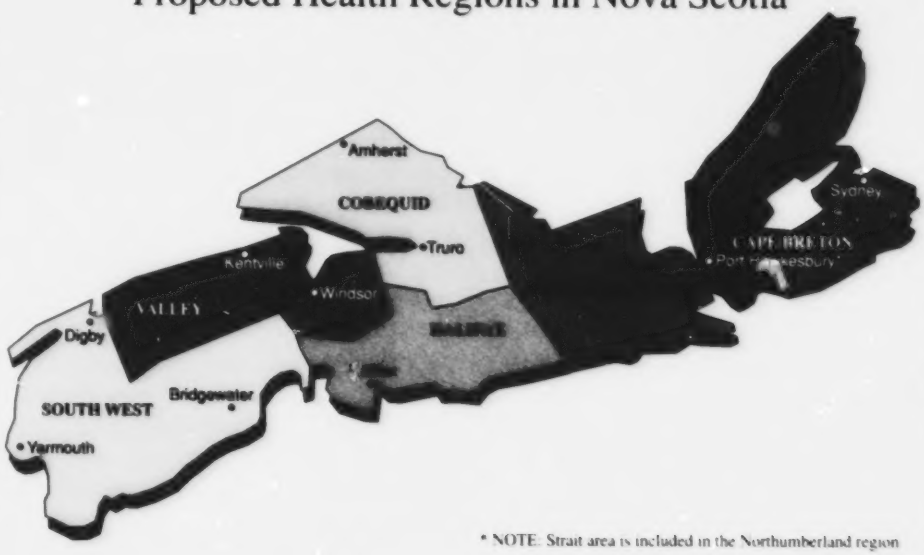
Figure 1

Regional Health Agencies

Health Region	Components	Population (est.)
Cape Breton	Cape Breton Island (excluding Strait area)	160,000
Cobequid	Colchester and Cumberland Counties; Noel shore area	85,000
Halifax	Halifax County; East Hants; (excluding Noel shore area)	335,000
Northumberland	Pictou, Antigonish and Guysborough Counties; Strait area.	85,000
South West	Yarmouth, Shelburne, Queens, Lunenburg and Digby Counties.	125,000
Valley	Kings and Annapolis Counties; West Hants.	88,000

Figure 2

Proposed Health Regions in Nova Scotia



* NOTE: Strait area is included in the Northumberland region

Reorganization of The Department of Health

The Department of Health will be reorganized for greater effectiveness. The Health Services and Insurance Commission (HSIC), the agency responsible for the Medical Services Insurance Plan, and the Nova Scotia Commission on Drug Dependency (CODD) — which to date have operated semi-independently — will become divisions within the Department of Health. Other divisions within the Department will be restructured to increase their effectiveness.

Under the reorganized structure of the Department of Health, there will be five operational divisions:

- Insured Professional Services [1]
- Drug Dependency Services [2]
- Health Care Facilities
- Community Health and Health Promotion
- Mental Health Services.

1. Formerly the Health Services and Insurance Commission
2. Formerly the Commission on Drug Dependency

There will be two support divisions:

- Policy and Planning
- Corporate Services

The main functions of the Department of Health will be strategic planning, operations and providing support for the new Regional Health Agencies.

The Department's name will be changed from Department of Health and Fitness to Department of Health, to reflect the department's commitment to the full range of health services.

The board of the Commission on Drug Dependency has to date provided the Minister of Health with valuable advice concerning substance abuse. To ensure that this community voice remains after the Commission is dissolved (and becomes the Drug Dependency Services Division of the Department of Health), Government will set up a Minister's Advisory Committee on Substance Abuse. The existing network of regional and community advisory boards on drug dependency will remain as well.

Coordination Among Government Departments

Many factors affect our health — the environment, the quality of our housing and general economic conditions, for example. To be truly effective, all governmental programmes which affect citizens' health and well-being must be coordinated.

At the provincial level, the Ministers of Health, Community Services, Education, Environment, Housing and Labour (and others as necessary) will meet regularly to plan and coordinate the health-related policies and programmes of their respective departments and agencies.

PART II
THE HEALTH PROFESSIONS

INTRODUCTION

In its review of the health professions, the Royal Commission on Health Care focused on three main professional groups: nurses, physicians, and associate health professionals (e.g. physiotherapists and occupational therapists).

The Royal Commission highlighted the need to integrate health professions planning with overall health policy. In response to this recommendation, Government will develop a comprehensive health human resource plan to ensure that health personnel is allocated based on the health needs of the population.

Nurses

As the health care system changes, the role of nurses is also evolving. Under the new Health Strategy, nurses will be called upon to play an enhanced role. Government will work with the nursing profession to develop policy proposals. Therefore, Government will establish a Task Force on Nursing. Within 24 months, the Task Force will make detailed recommendations to the Minister of Health in four areas:

- human resource planning for nurses;
- nursing education;
- professional development for nurses; and
- innovative nursing projects.

Members of the Task Force on Nursing will come from organizations directly concerned with nursing issues, and from appropriate government departments. Members will serve as volunteers.

Physicians

Physicians play a key role in the health care system. For example, they usually decide which health services (e.g. treatment from specialists, diagnostic tests from a laboratory, hospital services) a person should receive.

In 1989-90, the Medical Services Insurance (MSI) plan paid out $215 million to Nova Scotia physicians. Nova Scotia now ranks third among all Canadian provinces in the amount spent per person for physicians' services, up from sixth in 1972-73.

This increase in physician expenditures reflects several factors: Nova Scotians are using physicians' services more often; the number of doctors has increased significantly; and the fees paid to physicians have increased. Between 1970 and 1988, the number of physicians in Nova Scotia increased more than six times faster than the province's population. Yet in some areas of the province, there is still a shortage of doctors.

The Government aims to:

- ensure that all Nova Scotians have fair and equitable access to physicians' services; and
- improve the delivery of physicians' services, to ensure that Nova Scotians receive the best and most efficient care for their tax dollars.

To reach these goals, Government will develop and launch, in consultation with the medical profession, a strategy to manage the growth of physician supply and expenditures. This managed-growth strategy will include detailed policies on:

- the number of physicians available in the province, in total and by specialty;
- the number of physicians available in each area of the province; and
- the way physicians are paid (fee-for-service, salary or other methods).

Government will establish a Ministerial Committee on Physician Policy to carry out this process. This committee will make its recommendations to Government within 12 months. Those serving on the Committee will do so as volunteers.

Associate Health Professions

The associate health professions include over one hundred professional groups -- e.g. physiotherapists, occupational therapists and speech therapists. Government will develop a comprehensive plan that defines the most appropriate number and mix of professionals to deliver health services. This will be done in consultation with the health professions. As a first step, the Department of Health has begun to build a comprehensive database and information system covering all health professions.

PART III
REVITALIZED HEALTH SERVICES

Health Care Priorities

The Government's new Health Strategy, in keeping with the recommendations of the Nova Scotia Royal Commission on Health Care, will introduce shifts in emphasis within the health care system. The goal is to provide Nova Scotians with more effective health care and better personal health.

For example, the Government will, in partnership with health care professionals and the public:

- expand its health promotion and disease prevention programmes, which are recognized ways to improve health; and
- increase emphasis on community-based treatment services, such as home care and day hospital programmes, which are effective alternatives to hospitalization.

Nova Scotians' Health Status

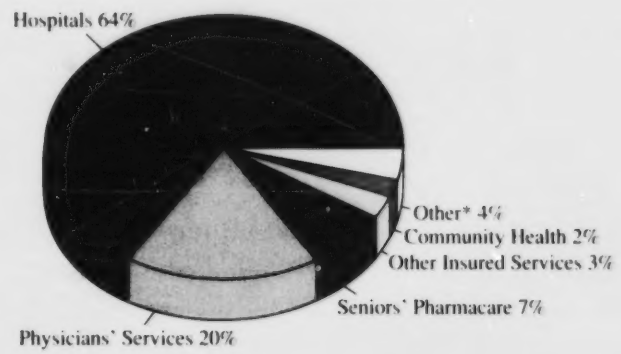
The health of Nova Scotians is poor compared to that of other Canadians. Nova Scotia has the highest rates of disability of all provinces. Our rates of death from lung cancer, diabetes and respiratory illness are among the worst in the country.

Health Care Spending

Most of the money the Nova Scotia Government spends on health care goes towards hospital operating costs and physicians' services: in 1989-90, the Department of Health and Fitness spent more than 80% of its operating budget on these two areas. In contrast, the Department spent only about two per cent of its budget on community health programmes — which include all health promotion and disease prevention activities *(see Figure 3)*.

Figure 3

Department of Health and Fitness Ordinary Expenditures, 1989-90



Source: Government of Nova Scotia Estimates, 1990 - 91

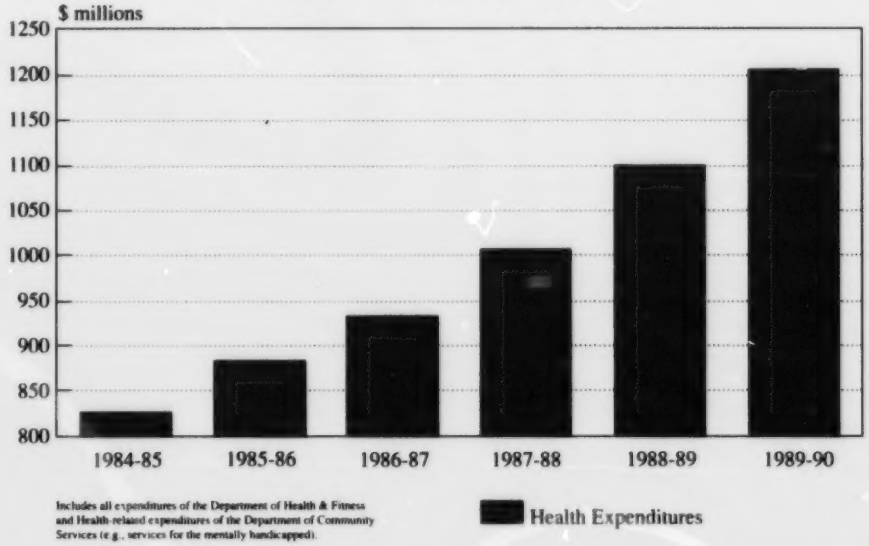
* Commission on Drug Dependency Coordinated Home Care Programme, general administrative costs

Provincial government health spending has increased rapidly in recent years, from $825 million in 1984-85 to $1.21 billion in 1989-90 *(see Figure 4)*. Health expenditures now account for almost 30 cents of every dollar spent by the Government of Nova Scotia.

By managing the health care budget more effectively, Government will improve the quality of health care while slowing the growth rate of provincial spending on health.

Figure 4

Nova Scotia Government Health Spending 1984-85 to 1989-90



Health Services

In order to provide Nova Scotians with more effective health care and better personal health, Government will take action in the following eight areas:

1. Primary Health Care

Primary Health Care is an approach that integrates the various components of the health care system — health promotion, disease prevention, treatment and rehabilitation. Its aim is to ensure that the health services provided to individuals and communities match their health needs, and that services are delivered in every case by the most appropriate health care professional.

The Department of Health will adopt the Primary Health Care approach, and will promote it throughout the province. The Department will help communities design and test Primary Health Care pilot projects. For example, a community might wish to open a health centre offering the services of a variety of health-care professionals under one roof.

2. Health Promotion and Disease Prevention

The Department of Health will substantially increase spending on health promotion and disease prevention programmes. The Department will reorganize its budget to increase funding for these programmes from 2.2 % of total Department spending to about 4% within five years.

Through its new Community Health Promotion Fund, the Department of Health will fund community-managed health promotion projects (e.g. activities related to fitness or nutrition).

3. Treatment Services

Government will increase support for community-based treatment services, such as home care and day hospital programmes, which can be effective alternatives to institutionalization.

The Department of Health will continue work already under way to improve the province's hospitals in a number of ways:

- The roles of the various hospitals in each region will be clearly defined, reducing wasteful duplication of services. This work has already begun in several regions (e.g. Cape Breton, Lunenburg-Queens).

- Regional planning for hospital-based medical specialties, which has been initiated throughout the province, will continue.

- The Department of Health will continue to support the shift from inpatient to community-based services (e.g. day hospital programmes).

- The Department will continue to support the evolution of community hospitals into community health centres, which provide a wider range of services.

- Government will continue to combine services of neighbouring hospitals and nursing homes in an effort to reduce duplication (e.g. of laundry and kitchen facilities).

4. Continuing Care

Nova Scotia now provides continuing care services to people with chronic illness or disability. These services are designed to maintain patients' health and quality of life. Existing continuing care services include Coordinated Home Care, Nursing Homes and Homes for the Aged.

In an effort to improve the services delivered, Government will strengthen continuing care management. For example, Government will look at developing a single entry point for all continuing care services in a given area. Government will also evaluate the Coordinated Home Care Programme. Once the evaluation is complete, Government will be able to consider expanding the Programme to include more services or new target groups. Existing arrangements for Level III care (often referred to as chronic care) will also be reviewed, in particular to determine if providing Level III care in Nursing Homes would be more appropriate and/or less costly than providing it in hospitals.

5. Mental Health Services

As with the health system as a whole, the main thrust of mental health services to date has been acute care and treatment, and in institutional settings.

The Government accepts the recommendation of the Nova Scotia Royal Commission on Health Care that mental health services be expanded to provide a broader range of services in the community. Included will be mental health promotion, outpatient services, home care, half-way houses, group living, sheltered workshops, and placement and outreach services.

The following will be given highest priority:

- child and adolescent services
- psychiatric rehabilitation
- forensic psychiatric services (youth and adult)
- human resource development in the mental health field
- programmes to deal with societal violence.

To improve its management, the Nova Scotia Hospital will be made an independent corporation, subject to the same rules and regulations as other hospitals in the province.

Furthermore, mental health professionals, users of mental health services and Government will join in reviewing the entire Nova Scotia mental health system. The goal of this review will be to ensure that, in future, Nova Scotia's mental health services match the needs of its population. To achieve this goal, the review body will draft a strategy for future delivery of mental health services in our province.

6. Drug Dependency Programmes

Community and regional advisory committees have developed programmes to combat drug abuse in each region of the province. This approach will be maintained, even as the Commission on Drug Dependency becomes a division of the Department of Health.

7. Ambulance Services

The Nova Scotia Royal Commission on Health Care recommended a policy review of ambulance operator training, equipment standards, and coordination of services. Government, with assistance from the newly-created Ambulance Services Advisory Committee, will improve ambulance services by carrying out the recommended review, and then taking appropriate action.

Work has begun to put in place a province-wide emergency number (911).

8. Pharmacare

Nova Scotia's Pharmacare plans cover prescribed drugs for people 65 years of age and over, and for disabled people receiving Family Benefits payments from the Department of Community Services.

Concern has been expressed about excessive and inappropriate use of prescription and over-the-counter drugs, especially among seniors. This concern applies particularly to the Pharmacare plans, where beneficiaries use an average of 25 prescriptions per year.

The Government has already put in place a number of policies on drug use and expense. One policy controls the cost of drugs insured under Pharmacare by limiting payment to the cost of the lowest price generic equivalent; another has set in motion a review of the therapeutic value of drugs insured under Pharmacare.

The Government will work with physicians, pharmacists and the public to publicize the dangers of inappropriate prescription and use of medications.

APPENDIX
LIST OF POLICY AND PROGRAMME INITIATIVES

Following is a list of all the initiatives contained in **HEALTH STRATEGY FOR THE NINETIES: Managing Better Health**:

CHAPTER I: A NEW PLANNING DYNAMIC

Provincial Health Council

The Provincial Health Council will provide a forum for broad public participation in health planning and in the establishment of Health Goals for the province. The Health Council will be established, and begin its work, immediately.

Interdepartmental Coordination

A Senior Interdepartmental Committee on Health Policies and Programmes will be created. The standing members of the Committee will include the Ministers and Deputy Ministers from the following departments: Health, Community Services, Education, Solicitor General, Environment, Housing and Labour. Representatives of other departments will be seconded as needed.

Regionalization of Health Planning and Services

Government will proceed as soon as possible with regionalization of health-related planning and services, by establishing Regional Health Agencies in all regions of the province.

Government will examine decentralization at a later date, based on evaluation of the experience with regionalization.

Six Regional Health Agencies will be established (based on regions depicted in the body of the report).

All divisions of the Department of Health will use these regions for planning and operational purposes.

Department of Health

Reorganization of the Department of Health will be addressed as a first priority.

These reorganizational measures are outlined below.

The Department of Health will be comprised of five operational divisions — Health Care Facilities, Insured Professional Services, Community Health & Health Promotion, Mental Health Services, and Drug Dependency Services — and two support divisions, Policy & Planning and Corporate Services.

The Department's name will be changed to "Department of Health." The title "Division Administrator" will be changed to be more consistent with other Departments in Nova Scotia and elsewhere: the title "Assistant Deputy Minister" (ADM) will be used for all divisional heads.

Regional coordinating groups will be established, one for each of the six proposed health regions. These groups will bring together appropriate staff for the region concerned so as to ensure coordination and integration of planning and service delivery.

The Department of Health will create and chair a Regional Health Agency Coordinating Committee, to be comprised of the chairpersons of the six Regional Health Agency boards and senior Department staff.

The Agreement with Maritime Medical Care Inc. (MMC) will be amended so that the Policy and Planning Division will assume responsibility for research and policy analysis with respect to MSI programmes.

The Agreement with MMC will be amended so that the Department of Health will assume a major role in systems development with respect to MSI programmes.

The Health Services and Insurance Commission will be integrated with the Department of Health, becoming the Insured Professional Services Division.

The following committees [related to insured professional services] will be established by the Minister of Health: a Negotiating Committee, a Due Inquiry Committee and an Insured Services Appeal Board.

To ensure that drug dependency services are fully integrated with other health services, the Commission on Drug Dependency will be integrated with the Department of Health, becoming the Drug Dependency Services Division.

The provincial advisory functions hitherto provided by the Commission on Drug Dependency will be maintained, by establishing a Minister's Advisory Committee on Substance Abuse.

CHAPTER III: HEALTH PROFESSIONS

Nurses

The Task Force on Nursing will be formed, and begin its work,as soon as possible.

Physicians

A Ministerial Committee on Physician Policy will be formed, and begin its work as soon as possible.

Associate Health Professions

A comprehensive health human resource management information system will be developed by the Department of Health, in consultation with the health professions.

The mandate of the Nova Scotia Advisory Commission on Health Human Resources will be expanded to include matters pertaining to all health professions in Nova Scotia.

CHAPTER III: REVITALIZING SERVICES

Spending on community health programmes, including health promotion, will be increased from 2.2% to approximately 4% of the Department of Health budget within five years. This will be achieved by internal reallocation within the Department's overall budget.

The rate of increase of total provincial government spending on health will be reduced.

Primary Health Care Delivery

The Government of Nova Scotia will promote the Primary Health Care approach in all regions of the province. The Department of Health will integrate Primary Health Care delivery principles into its departmental Strategic Plan.

The Department of Health will set up a Working Group on Primary Health Care Delivery to help communities develop integrated approaches to primary health care. The Working Group will work in consultation with other departments and agencies involved in related service delivery.

Community Health and Health Promotion

A committee with joint participation by the Community Health and Health Promotion Division's central office and the Regional Health Units will be established to maintain definition of their respective priorities, roles and objectives.

Acute Care

Rationalization of the hospital sector has been initiated by the Department of Health and Fitness, and will be continued.

Continuing Care

The management of continuing care will be strengthened.

The following specific measures will be undertaken:

1. The Home Care Coordinating Agency will be renamed the Continuing Care Coordinating Agency and its mandate will be broadened to include all continuing care services (including the Coordinated Home Care Programme — CHCP). The Continuing Care Coordinating Agency will provide policy direction and leadership. It will work in close conjunction with Regional Health Agencies in meeting the mandate of coordinating continuing care services at the regional level.

2. The possibility of establishing a single entry point for all continuing care services in each area of the province will be examined. These entry points would operate according to provincial standards and guidelines to be established under the auspices of the Continuing Care Coordinating Agency.

3. Within the Community Health and Health Promotion Division of the Department of Health, separation of the CHCP nursing-care component from the community health nursing function (health promotion and disease prevention) will be instituted.

4. An evaluation of the Coordinated Home Care Programme (CHCP) is being undertaken. After this evaluation is complete, the desirability of expanding the CHCP to include additional services and/or target groups will be examined. In addition, the question of which division within the Department of Health should administer the CHCP will be reviewed. (Home Care is a treatment programme, and as such should eventually be administered by the Facilities Division, which has responsibility for treatment services.)

5. A review of Level III care will be undertaken, in particular to determine if providing Level III care in Nursing Homes would be more appropriate and/or less costly than providing it in hospitals.

Mental Health Services

The Nova Scotia Hospital will become an independent corporation, subject to the same rules and regulations as other hospitals in the province.

A Working Group on Mental Health Services will be established by the Minister of Health.

Ambulances

Government supports the establishment and priorities of the Ambulance Services Advisory Committee, in keeping with the recommendation of the Nova Scotia Royal Commission on Health Care, and will promote enhanced management of ambulance services in Nova Scotia.

Pharmacare

An Advisory Committee on Drug Utilization will be formed.

Health Strategy for the Nineties: *Managing Better Health*

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1700 Granville Street
One Government Place
P.O. Box 637
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B3J 2T3

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TABLE OF CONTENTS

PREFACE v

INTRODUCTION AND OVERVIEW vii

CHAPTER I A NEW PLANNING DYNAMIC 1

Introduction 1
Part 1 Provincial Health Council 2
Part 2 Interdepartmental Coordination 3
Part 3 Regionalization of Health Planning and Services 5
Part 4 Department of Health 10

CHAPTER II HEALTH PROFESSIONS 21

Introduction 21
Part 1 Nurses 22
Part 2 Physicians 23
Part 3 Associate Health Professions 26

CHAPTER III REVITALIZED SERVICES FOR THE CONTINUUM OF CARE 29

Introduction 29
Part 1 Primary Health Care Delivery 30
Part 2 Community Health and Health Promotion 32
Part 3 Acute Care 35
Part 4 Continuing Care 37
Part 5 Mental Health Services 40
Part 6 Drug Dependency Services 45
Part 7 Ambulances 46
Part 8 Pharmacare 47

APPENDICES: 51

I Health Expenditures, 1984/85 - 1989/90 51
II Provincial Health Council 53
III Background to Regionalization Strategy 59
IV The Health Services and Insurance Commission/Maritime Medical Care Inc. 65
V Department of Health 69
VI Task Force on Nursing 75
VII Ministerial Committee on Physician Policy 79
VIII Working Group on Primary Health Care 83
IX Working Group on Mental Health Services 87
X Ambulance Services Advisory Committee 89
XI Advisory Committee on Drug Utilization 91
XII Summary of Policy and Programme Initiatives 95

GLOSSARY OF TERMS 101

PREFACE

In December 1989, the Nova Scotia Royal Commission on Health Care presented its Report to Government and the public. The Royal Commission's Report was based on extensive research, public hearings and consultation with health care providers, consumers and experts.

In the February 22, 1990 Speech from the Throne, Government indicated its general acceptance of the Royal Commission Report and announced several initial measures, based on recommendations made by the Royal Commission. These were:

- the formation of a Provincial Health Council;
- a Task Force on Nursing;
- a modified Pharmacare Programme;
- a coordinated policy on physicians' services; and
- the Community Health Promotion Fund.

Following the Throne Speech, The Minister of Health's Implementation Committee was formed in April, 1990. The Committee's mandate was to develop Government's overall response to the Royal Commission's recommendations and elaborate a new strategy for health.

The work of the Committee was headed by Martine Durier-Copp, Ph.D., the former Executive Director of the Nova Scotia Royal Commission on Health Care. Membership was comprised of staff seconded from the Department of Health and Fitness as well as external consultants. They were: Rick Cameron, Vern Hicks, Jim Houston, Victor Maddalena, Christiane Poulin, M.D., Sheila Ross, Theresa Marie Underhill and Judith Wood-Bayne.

The Minister's Implementation Committee undertook detailed analysis of the Royal Commission's recommendations. The Committee also consulted internally with staff of the Department of Health and Fitness and externally with appropriate interest groups and government departments. This document, **HEALTH STRATEGY FOR THE NINETIES: *MANAGING BETTER HEALTH***, reflects the results of that analysis and consultation.

HEALTH STRATEGY FOR THE NINETIES is organized as follows:

- The document begins with an **Introduction** and **Overview**.

- **Chapter I** describes the mechanisms for improved planning and management of health services: these include the Provincial Health Council, new Regional Health Agencies, a reorganized Department of Health, and key inter-departmental committees.

- **Chapter II** focuses on the health professions: nurses, physicians and associate health professionals.

- **Chapter III** describes measures to revitalize the various health services within the continuum of care.

- **Appendices** and a **Glossary** of terms used in the document follow Chapter III.

INTRODUCTION AND OVERVIEW

HEALTH STRATEGY FOR THE NINETIES indicates the directions the Government of Nova Scotia intends to pursue in reforming the province's health system. It outlines a policy framework which will initiate fundamental changes to that system.

These fundamental changes to the health system are based on the **Guiding Principles** outlined in the Report of the Nova Scotia Royal Commission on Health Care, presented in December, 1989. Government accepts the long-term strategy described in the Royal Commission's Report, and specifically endorses the following principles: Health Policies Oriented to Healthy Outcomes; Participation of Citizens; Regionalization; Accountability; and Matching Resources to Health Needs. **HEALTH STRATEGY FOR THE NINETIES** contains Government's comprehensive response to the Royal Commission Report.

The health system in place today in Nova Scotia is largely a legacy of the insurance programmes for hospital and physicians' services initiated more than 20 years ago. The emphasis has been placed on development of hospital infrastructure and medical care: **more than 80% of the budget of the Department of Health and Fitness is allocated to hospital operating costs and physicians' fees** (see Figure 1).

The average occupancy rate of beds in Nova Scotia hospitals is well below the comparable national figure,[1] which suggests a surplus of beds. Action to reduce the surplus has been initiated by the Department of Health and Fitness.

In terms of per capita expenditure on physicians' services, Nova Scotia moved from ranking sixth among all provinces in 1973 to third in 1986, and physician supply increased dramatically. Between 1970 and 1988, the supply of physicians increased by 88% (in full-time equivalent terms), compared to a 13% increase in the province's population.

Pharmacare is the fastest-growing area of health expenditures. Over the past 10 years, Pharmacare costs have increased by an average of 18% p.a., and in 1990-91 are estimated to total more than $80 million.

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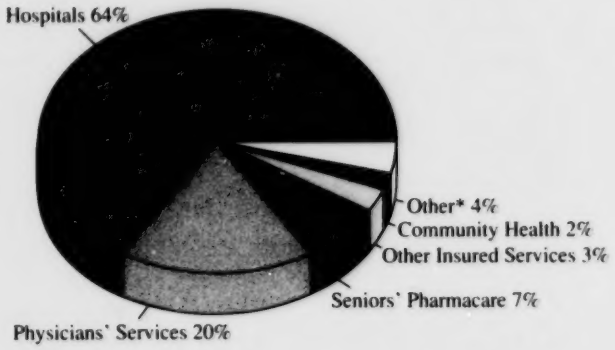
1. In 1987-88, the occupancy rate for all hospitals in Nova Scotia was 73%, compared to a national average of 84%. Source: Statistica Canada. *Hospital Statistics Preliminary Annual Report 1987-88*. (Ottawa; Oct., 1989).

Figure 1

Department of Health and Fitness Ordinary Expenditures, 1989-90



Source: Government of Nova Scotia Estimates, 1990 - 91

* Commission on Drug Dependency Coordinated Home Care Programme, general administrative costs

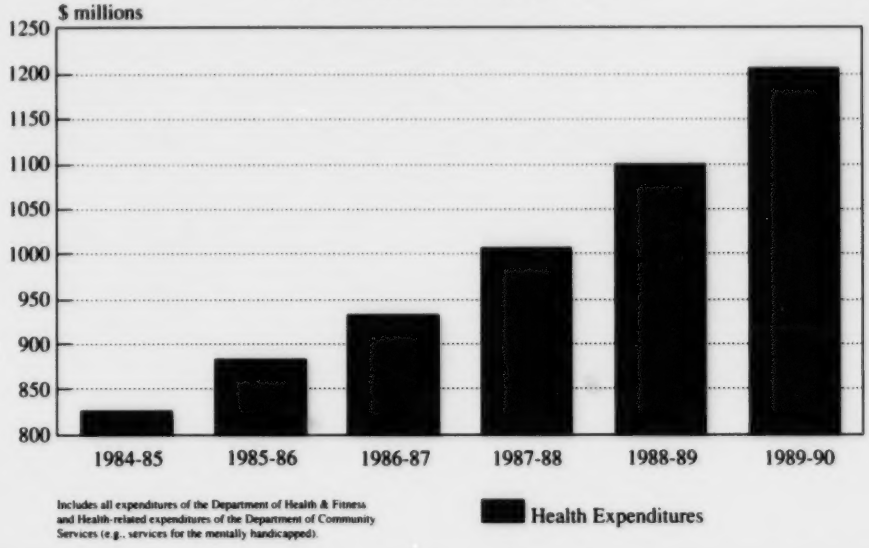
As a result of increased expenditures for hospitals, physicians and Pharmacare, **total provincial government health expenditures have grown rapidly** in recent years, from $825 million in 1984-85 to $1.21 billion in 1989-90 (see Figure 2). During that period, provincial government health spending[2] grew by an average of 7.9% per annum, versus 6.2% p.a. for the overall provincial government budget.

Health expenditures in fiscal year 1990-91 will reach an estimated $1.27 billion, which is 29.4% of estimated total provincial spending. Health spending is the single largest component of the provincial budget.

2. Provincial government health spending includes all expenditures of the Department of Health and Fitness ($1.1 billion in 1989-90) plus health related expenditures of the Department of Community Services ($110 million in 1989-90).

Figure 2

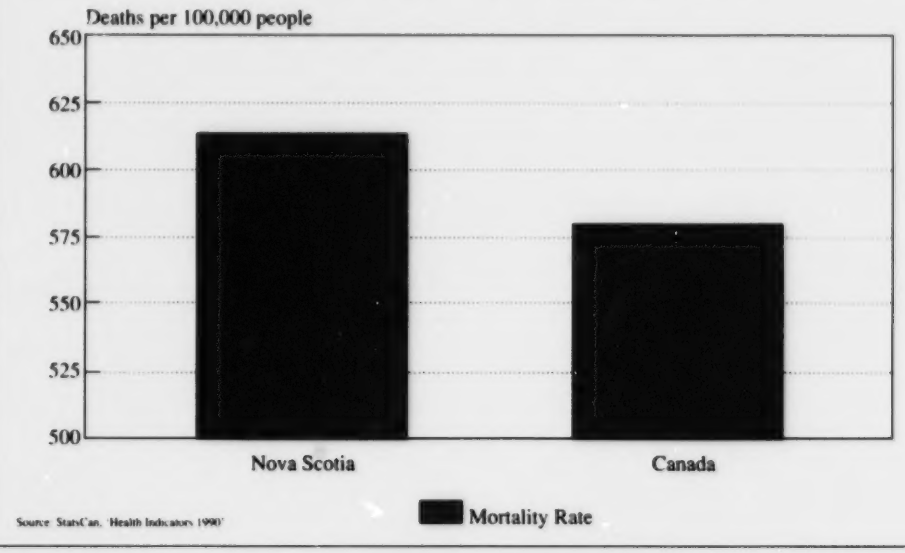
Nova Scotia Government Health Spending 1984-85 to 1989-90



High levels of health expenditure in Nova Scotia have not been associated with good health outcomes: **the health status of Nova Scotians is poor compared to the health of residents of other provinces**. For example, Nova Scotia's overall rates of mortality and disability are the highest in the country (see Figures 3 and 4). Nova Scotian male death rates are above the national average for four of the leading causes of death in Canada: heart diseases; cancers; accidents; and cerebrovascular diseases. Female death rates in Nova Scotia are above the national average for three of the leading causes of death: heart diseases; cancers; and respiratory diseases.

Figure 3

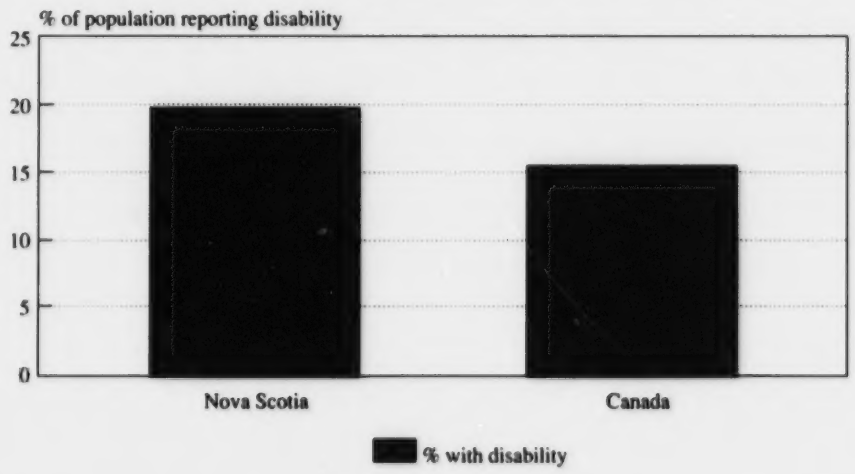
Mortality Rates
Nova Scotia and Canada, 1986



Source: StatsCan, 'Health Indicators 1990'

Figure 4

Disability Rates
Nova Scotia and Canada, 1986-87



Source: StatsCan, 'Health Indicators 1990'

In view of these health status and expenditure indicators, **HEALTH STRATEGY FOR THE NINETIES** presents a blueprint intended to achieve **optimal health outcomes and more efficient management** of health care resources. This document sets out immediate and medium-term measures to realize these goals.

In addition to the Royal Commission's Guiding Principles, the following five precepts underlie the new **Health Strategy:**

1. Nova Scotians will be offered the **full continuum of care**, ranging from health promotion and disease prevention to primary treatment, referral services and rehabilitation. This will entail a shift in emphasis from acute care to health promotion and a corresponding reallocation of resources.

2. Within the continuum of care, increased emphasis will be placed on **Primary Health Care**. Primary Health Care is the first level of contact of the public with the health system. It places particular emphasis on health promotion and disease prevention, and includes treatment services. Primary Health Care will promote increased integration among all components of the health system. In the past two decades, the province has put in place an excellent network of referral facilities (regional and tertiary-care hospitals). The nineties will see these referral facilities maintained, with a shift in emphasis in the overall health system to strengthening primary care. The share of the Department of Health budget devoted to community health will be increased, and a Working Group on Primary Health Care Delivery will be set up to oversee the development and evaluation of pilot projects at the local level.

3. Nova Scotia's health system must be **community-based, flexible** and **responsive to users' needs.** This will entail a shift from inpatient institutional care to community-based services, such as home care and day hospital services.

4. The services and programmes that comprise the health system must be **comprehensive, integrated** and **coordinated**, recognizing the inter-dependence of various determinants of health. This will entail a broader approach to **health planning and delivery**, as provided for in the Provincial Health Council, six new Regional Health Agencies, a reorganized Department of Health, and various inter-departmental mechanisms (e.g. a new coordinating committee for continuing care).

5. Nova Scotia's health system must be managed to effectively **reduce the rate of growth of health expenditures.** This will involve maximizing the effectiveness of health spending and rationalizing services. For example, significant progress in reducing over-capacity of hospital beds and developing regional plans for medical specialities has already been made. A Ministerial Committee on Physician Policy, with participation of physicians and other interested parties, will be established to address the issue of overall physician supply and expenditures.

Nova Scotians can be proud of the accomplishments of their health care system. Since the inception of Medicare, a universal system of hospital and medical care has been realized for the province. Building on this base, it is now important to redirect the emphasis that has been placed on the acute care treatment component of Nova Scotia's health system to achieve:

- improved health status for Nova Scotians; and
- a more comprehensive, integrated and efficient health system that will respond more effectively to the health needs of the citizens of this province.

CHAPTER I
A NEW PLANNING DYNAMIC

INTRODUCTION

The Report of the Nova Scotia Royal Commission on Health Care recommended the establishment of a new planning dynamic in Nova Scotia's health system, which would fundamentally restructure the health policy development process and redefine relationships among Government, providers, and consumers. Founded on the Royal Commission's five Guiding Principles (described in the Introduction and Overview to this document), the new planning model calls for greater **participation** of health care providers and consumers in the design and strategic orientation of the province's health system. This increased participation would occur both at the provincial level and at the regional level within the province. The new planning model would also demand more **accountability** of the system, ultimately focusing on health **outcomes** as the driving factor.

The new planning dynamic put forward by the Royal Commission is predicated on a broadened vision of health, termed a **Comprehensive Health Policy**. Based on the principles of equity, participation and an intersectoral, ecological approach, the Comprehensive Health Policy views the health care system as but one of the many determinants that affects the health of a population.

This broadened approach to health planning, embodied in the newly-created **Provincial Health Council**, will involve many sectors of society and bring a multi-dimensional character to the design of public policy. Better coordination within a reorganized **Department of Health** will link health policy planning across traditional divisional boundaries (e.g. health care facilities and community health services) and promote greater integration in the strategic planning process. Likewise, **strengthened coordination of efforts among governmental departments**, notably the Departments of Health and Community Services, will reflect the new emphasis placed on the full continuum of services offered to Nova Scotians.

Under the new Health Strategy, the regions will play an integral role in the planning process. Six regions are proposed, each constituted with a **Regional Health Agency**. Operating within the framework of Provincial Health Goals, the Regional Health Agencies will provide advice to the Minister of Health on the full spectrum of health issues within their respective jurisdictions.

As recommended in the Report of the Royal Commission on Health Care, an Act to establish the Provincial Health Council was passed at the 1990 session of the Legislature. The Act defines the Health Council's duties, membership and functioning.

With rising health care costs and fiscal constraints, it is essential that a context of accountability, effectiveness, and outcome measurement be adopted for the health care system. The Government of Nova Scotia recognizes that the greatest potential for change in this direction lies in the participation of the citizens of this province in shaping the orientation of the system.

The Provincial Health Council will provide a forum for broad public participation in health planning and in the establishment of Health Goals for the province. The Health Council will be established, and begin its work, immediately.

Through its intersectoral membership, the Health Council will promote a more global approach to health planning. The Health Council will play a consultative role, providing Government with advice on the general direction of the health system in Nova Scotia. Reporting to the Executive Council, through the Minister of Health, the Provincial Health Council will advise Government on planning and priorities, complementary to the provincial Department of Health.

There are numerous determinants which have an impact on the health status of the population. It is expected that the Provincial Health Council will place emphasis on these determinants of health, not just those related to the formal health care system. Many of these determinants fall outside the jurisdiction of the Department of Health. The Provincial Health Council will thus establish liaison with other governmental departments and agencies. These must include areas such as social services, the environment, industry, economic planning, and education. The Council will also foster an environment in which all services delivered through the health care system are targeted towards the achievement of defined health outcomes.

Mandate

The Provincial Health Council will assist the Government of Nova Scotia in the development of a Comprehensive Health Policy and Health Goals, and in setting overall direction for the health care system. It will play a strategic communications role for Government by inviting community organizations, health care

providers and consumers, and the general public to provide comment on health issues under review.

The Health Council will solicit advice and information from a broad range of interest groups and the public through means such as public symposia, hearings, and distribution of briefs and discussion papers. By virtue of its broad, representative membership and its consultative activity, the Provincial Health Council will provide a balanced and informed view of the health care system.

The Health Council will also review particular issues referred by Government, and will provide recommendations and advice as required. The Health Council will be accountable to Government, through the Executive Council and the Minister of Health, reporting on a regular basis in an **Annual Report** on progress made in achieving Health Goals and objectives. It will identify major strengths and shortcomings of the system.

The terms of reference, membership, and sub-committee structure for the Provincial Health Council are discussed in Appendix II.

PART 2: INTERDEPARTMENTAL COORDINATION

Two fundamental tenets of planning for human services (including health and social services) which underpin the strategy outlined in this document are as follows:

(i) The focus of all planning must be the health of Nova Scotians and their overall needs (rather than departmental or programme structures).

(ii) Health services and social services must be seen as an integrated model that ranges from health promotion strategies (e.g. anti-smoking policies and programmes) to community-based services (e.g. home care, public housing) to institutional services (e.g. inpatient hospital care).

The implication is that all governmental activities that affect citizens' health and well-being — no matter where the activities fall within the model, or which department delivers them — must be coordinated to ensure that the overall impact is as beneficial as possible.

The Report of the Royal Commission on Health Care emphasized the need for increased coordination among government departments whose policies and programmes have an impact on health. Closer collaboration between the Department of Health, the Department of Community Services and other relevant government departments is required — at the provincial, regional and local levels.

Better coordination of all departments' health-related policies and programmes will help to: eliminate service gaps; increase efficiency and effectiveness in the delivery of health services; enhance cooperation among professional service providers; and clarify the respective responsibilities of the municipal and provincial levels of government.

For example, increased coordination and integration of the long-term care (Levels II and III) services offered by the Departments of Community Services and Health respectively is needed in order both to eliminate gaps in service and to rationalize service delivery.

Differences exist among departments having health-related mandates, regarding matters such as: relative emphasis on institution-based services versus community-based services; regional boundaries; internal policies on finance and administration; and funding of levels of care. Improved interdepartmental coordination will ensure that these differences are taken into account and, where appropriate, eliminated.

Several interdepartmental coordinating committees currently exist. These include: (a) the committee with representation from the Departments of Health, Education, Community Services and the Attorney General's Office; and (b) the Liaison Committee between Health and Community Services. However, none of the existing committees has a mandate or membership broad enough to: (a) achieve the overall interdepartmental coordination that the new health strategy requires; and (b) provide an overall framework for integrated policy development and programme planning.

Therefore,

A Senior Interdepartmental Committee on Health Policies and Programmes will be created. The standing members of the Committee will include Ministers and Deputy Ministers from the following departments: Health, Community Services, Education, Solicitor General, Environment, Housing and Labour. Representatives of other departments will be seconded as needed.

The mandate of this Committee will include:

- Ensuring that the health-related policies and programmes of all departments are developed with a broad view of health and its determinants, and that such policies and programmes are coordinated.
- Interdepartmental strategic planning for "at risk" groups, such as seniors, the mentally ill, children and adolescents.

- Developing standardized regions for health-related programmes and services.

Additional mechanisms to increase coordination at the regional level in particular are outlined in Part 3 of this chapter.

PART 3: REGIONALIZATION OF HEALTH PLANNING AND SERVICES

The Royal Commission on Health Care proposed five Guiding Principles to form the basis of a new health strategy for Nova Scotia. One of the proposed principles was "the dual concept of decentralization and regionalization." [1]

It is important to differentiate regionalization from decentralization. The Royal Commission defined the two terms as follows: "Regionalization involves the adaptation of a network of services to the needs of a region, and decentralization further entails delegation of responsibility and [operating] authority to regional bodies." [2]

The Royal Commission recommended **decentralization** of authority for health services. The Commission recommended that autonomous agencies known as Regional Health Authorities be established. These would be responsible for "...the planning and management of the full complement of health services and programmes delivered within their regions." [3] Specifically, each Regional Health Authority would receive a 'block grant' (based on the region's population and epidemiological status) from the provincial government, and would have the budgetary authority to allocate that block grant to "...the particular mix of health programmes that, in its judgment, best meets regional needs and priorities, in accordance with provincial guidelines." [4]

1. **The Report of The Nova Scotia Royal Commission on Health Care**, (Halifax, Nova Scotia; December,1989), page 3.
2. Ibid., page 4.
3. Ibid., page 52.
4. Ibid., page 53.

A Strategy for Regionalization

Government will proceed as soon as possible with regionalization of health-related planning and services, by establishing Regional Health Agencies in all regions of the province.

Government will examine decentralization at a later date, based on evaluation of the experience with regionalization.

The Regional Health Agencies will be **advisory** bodies, with the Department of Health retaining final authority regarding the health care budget. The Regional Health Agencies will examine the full range of health-related services in their regions.

Rationale

In establishing Regional Health Agencies, Government will be building on the successful examples of regionalized approaches that already exist in the province: the Cape Breton Regional Services Committee, the Metropolitan Hospital Advisory Committee, the Lunenburg-Queens Planning Council, etc.

Regionalization has the support of all respondents to the Royal Commission Report who expressed an opinion on the issue. On the other hand, there is not as yet agreement among interested parties as to the benefits of decentralization of authority.

The decision to proceed with regionalization is intended to help achieve the following objectives:

- Increase the **responsiveness** and **flexibility** of the health system to meet regionally-defined priority needs, as identified by participants in the system (users and providers).

- Increase the degree of **coordination** and **integration** of health services delivered by various providers, thereby improving the quality of service provided.

- Increase the **efficiency** of the health care system, notably by facilitating rationalization of services on a regional basis.

- Promote greater **participation** by citizens in health planning.

- Strengthen the role of the **community hospital** or health centre within the overall health system.

Regionalization is intended to apply to the entire spectrum of health-related services, including those which lie outside the health care system but which nevertheless directly affect health — e.g. social services such as care for the elderly, and health education provided in schools.

Regional Health Agencies

(a) The Regions and their Boundaries

Six Regional Health Agencies will be established, based on the following regions (depicted on Figure 5).

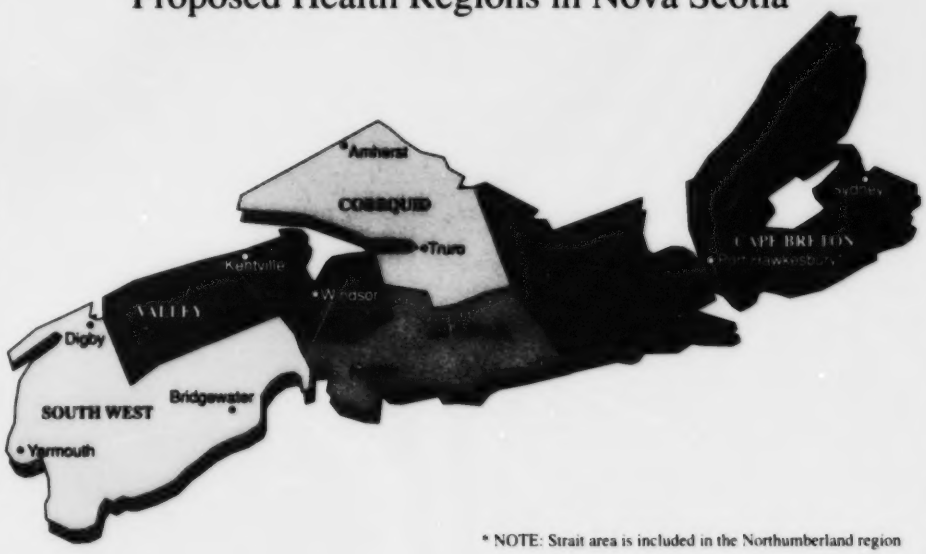
FIGURE 5
REGIONAL HEALTH AGENCIES

Health Region	Components	Population (est.)
Cape Breton	Cape Breton Island (excluding Strait area)	160,000
Cobequid	Colchester and Cumberland Counties; Noel shore area	85,000
Halifax	Halifax County; East Hants; (excluding Noel shore area)	335,000
Northumberland	Pictou, Antigonish and Guysborough Counties; Strait area.	85,000
South West	Yarmouth, Shelburne, Queens, Lunenburg and Digby Counties.	125,000
Valley	Kings and Annapolis Counties; West Hants.	88,000

In determining the number of health regions and the regional boundaries, the following factors were considered: population size (a minimum of 80,000 per region is seen as necessary for an effective regional approach); population distribution; traditional referral and utilization patterns for health services; common health interests; regional economic and sociological identity; existing boundaries used by divisions and agencies of the Department of Health and Fitness; availability of health data; and responses to the Royal Commission Report.

Figure 6

Proposed Health Regions in Nova Scotia



* NOTE: Strait area is included in the Northumberland region

Regional boundaries will be used to facilitate planning and service rationalization. Boundaries will not be used in any restrictive manner; for example, residents of a given region will not be restricted as to which hospitals they may use. In addition, regional boundaries may be adjusted as required.

All divisions of the Department of Health will use these regions for planning and operational purposes.

The choice of a regional office will be determined by each Regional Health Agency.

(b) Mandate of the Regional Health Agencies

The Regional Health Agencies will be advisory bodies, responsible to the Minister of Health. They will have a voice, but not final decision-making authority, in all health policy, planning and operations for their region.

The Agencies will operate in the context of Provincial Health Goals and policies formally established by the Minister of Health. The Agencies may act on their own initiative to address local issues; they will also respond to governmental requests for their advice on given issues. The Department of Health, and other departments as appropriate, would routinely seek comment from Regional Health Agencies on all matters affecting health and health care in their regions.

Because Regional Health Agencies will deal with the complete spectrum of issues related to health, a number of existing regional health planning and advisory bodies that have a more specific focus may become sub-committees of the new Regional Health Agencies. These include the Cape Breton Regional Services Committee, the Metropolitan Hospital Advisory Committee, the Metropolitan Mental Health Council, the Lunenburg-Queens Planning Council, regional advisory committees on drug dependency, and regional advisory committees on mental health.

By establishing Regional Health Agencies, Government is:

- committing itself to regionalization as a means of increasing the responsiveness, integration and efficiency of health services; and
- inviting existing institutions, agencies and associations to participate in making regionalization a success.

The Regional Health Agencies will not be restricted to considering issues that fall exclusively under the jurisdiction of the Department of Health. For example, to address the needs of the elderly, Agencies will consider matters that fall under the Department of Community Services (e.g. level II care in Homes for Special Care), and to address adolescent health, Agencies will consider topics that fall under the Department of Education (e.g. health education in the schools).

(c) Membership of Regional Health Agency Boards

The membership of the Regional Health Agency boards will vary by region, so that the membership of a given region's board reflects all key aspects of health and health care in that particular region (including aspects that do not come under the jurisdiction of the Department of Health). The interests of all key service providers in the region will be represented. The board will have an equitable balance of health care users (including community groups) and providers. The board's members will come from diverse backgrounds.

The total number of voting members on each Regional Health Agency board (which may vary from region to region) will be kept small enough to ensure that the board is functional.

Members of Regional Health Agency boards, and the chairpersons, will be appointed by the Minister of Health, following a process of consultation with interested parties and a public call for nominations.

Further details about the Regional Health Agencies' functions, tasks and operations (including board membership) are contained in Appendix III.

PART 4: DEPARTMENT OF HEALTH

Introduction

The Royal Commission on Health Care recommended a reorganization of the Department of Health's structure and operations in order to promote better planning and delivery of health services. The Royal Commission proposed that the new Department of Health be comprised of: the existing Department of Health and Fitness; the Health Services and Insurance Commission (which would assume some of the functions currently carried out by Maritime Medical Care Inc.); and the Commission on Drug Dependency.

The Royal Commission also argued for a strengthened and upgraded Policy and Planning Division and better health information systems, which would support and coordinate the functions carried out in the operational divisions of the Department and in the regions. Enhanced information systems are needed to provide a solid basis for policy development and responsive decision-making.

The new planning framework and the principle of regionalization will redefine the role and orientation of the Department of Health. The Department will develop a departmental **Strategic Plan** (based on the Provincial Health Goals), and be responsible for standards and guidelines, quality assurance, programme evaluation and the monitoring of health outcomes. The Department will also offer support to the planning efforts of the newly-created Regional Health Agencies.

The departmental model proposed herein is one which will optimize horizontal integration:

- between planning and operational units;
- among programme areas (intra-departmental); and
- between the Department of Health and other government departments, such as Community Services (inter-departmental).

It is intended to depart from the vertical top-down orientation that currently dominates departmental activities to a lateral approach allowing for greater integration cutting across traditional divisional lines. Eventually, these coordinated efforts should enable the adoption of **programme-based planning**, which could set targets by group (e.g. single parents, economically disadvantaged persons) or by type of service (e.g. continuing care), allowing for the development of service "clusters" to address the requisite health needs.

The creation of **Regional Health Agencies** will require an organizational structure that can provide planning and technical support for regional planning efforts and operations, particularly in terms of informational resources.

The departmental reorganization proposed herein is based on the Royal Commission's Guiding Principles, most notably: an **orientation to health outcomes, regionalization and accountability**. The proposed reorganization is intended to support the recommended shifts in orientation, namely:

- from the institution to the community; and
- from treatment/curative services to health promotion and disease prevention;

with the ensuing reallocation of human and capital resources to support this redistribution.

Finally, to be truly effective, this reorganization model must rest on a revitalized **human resource management strategy**. Effective and accountable management presumes a cadre of strategically-oriented professionals committed to a broad vision of health, to regionalization, and to community-based services. Secondments, rotations and continuing education opportunities should be offered to Department of Health personnel in an effort to keep professional staff current and motivated. Rotation of management staff from Regional Health Agencies to work within the Department should be considered as a method of training regional staff, and of fostering the professional relationships that will be a necessary condition for Department/regional cooperation.

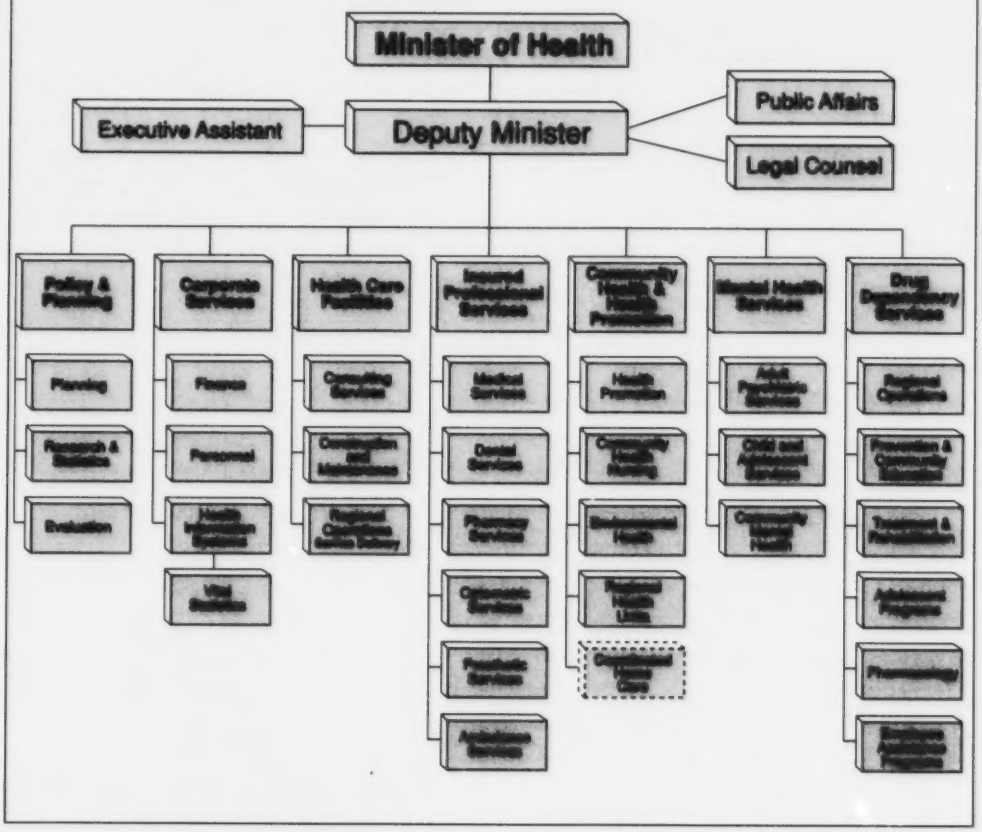
Reorganization of the Department of Health will be addressed as a first priority.

These reorganizational measures are outlined below.

The Department of Health will be comprised of five operational divisions — Health Care Facilities, Insured Professional Services, Community Health and Health Promotion, Mental Health Services, and Drug Dependency Services — and two support divisions, Policy and Planning and Corporate Services (see Organization Chart, Figure 7).

Figure 7

Nova Scotia Department of Health



The Department's name will be changed to "Department of Health". The title "Division Administrator" will be changed to be more consistent with other Departments in Nova Scotia and elsewhere: the title "Assistant Deputy Minister" will be used for all divisional heads.

Planning Activities

The Department of Health's principal vehicle for increasing the degree of integration and coordination among its operational divisions will be a departmental **Strategic Plan**. The Strategic Plan will outline the department's policies and priorities. It will include an analysis the operational activities of the department, and will propose resource allocations and financial targets by programme area. The Strategic Plan will be prepared within the context of the Comprehensive Health Policy and Health Goals developed by the Health Council and adopted by Government.

Development of the **Strategic Plan** will be coordinated by the Policy and Planning Division. Implementation of the **Strategic Plan** will be the responsibility of an interdivisional committee chaired by the Assistant Deputy Minister of Policy and Planning.

Each operational division will be responsible for developing sound plans within its own field of operation, drawing on resources of the Policy and Planning Division as required. A specific planning **unit** will be established only in the Policy and Planning Division, in accordance with the Royal Commission recommendation that specialized skills required for effective planning, analysis and evaluation be concentrated within the Policy and Planning Division.

Both the Policy and Planning Division and the Corporate Services Division will have their mandates expanded to ensure the successful implementation of the new **Health Strategy** outlined in this document. These two divisions will play a fundamental role in providing the data, research and policy analysis needed to ensure that health planning and services respond to regionally-defined priorities and are based on empirical analysis of health status and outcomes. These divisions will support the work of several agencies: the Department itself, interdepartmental committees, the Provincial Health Council and the new Regional Health Agencies.

Policy and Planning Division

(a) Mandate

The Royal Commission stressed the need for a stronger planning and policy development function. Consequently, a separate division, entirely dedicated to policy and planning, will be established. This Policy and Planning Division will be responsible for coordinating and giving impetus to system-wide strategic planning.

The Division will ensure the coordination and integration of all policy development and planning efforts, at the provincial level (Health Council and Department of Health) and at the regional level, with the Regional Health Agencies. Research and evaluation will be linked to policy formulation at all levels. This will include a strengthening of the department's capacity in the area of epidemiology (the study of determinants of health and disease, including the effectiveness of treatments). To ensure all planning is based on sound epidemiological information, the Policy and Planning Division will be responsible for the epidemiology function.

The Policy and Planning Division will act as a resource and support to operational divisions, as well as to the Minister of Health and the Deputy Minister. Actual research, planning and evaluation projects will be identified by a departmental planning process.

The Policy and Planning Division will coordinate the development of the department's Strategic Plan. It will also provide research and statistical support to the Provincial Health Council, as required, in the formulation of Health Goals. Likewise, it will provide assistance to the Regional Health Agencies.

(b) Structure

Three units will comprise the Policy and Planning Division: planning, evaluation, and research & statistics. The units' respective responsibilities are outlined in Appendix V.

(c) Regionalization

Regionalization of health planning and services (as proposed in Part 3 of this chapter) will necessitate that Department of Health staff adopt a regional approach. Horizontal communication and coordination across the Department's operational divisions will be vital, as will effective communication by the Department with the Regional Health Agencies. The Policy and Planning Division will have a key role to play in both of these areas. The following specific actions will be taken:

Regional Coordinating Groups will be established in the Department of Health, one for each of the six proposed health regions. These groups will bring together appropriate staff for the region concerned so as to ensure coordination and integration of planning and service delivery.

For example, the Cape Breton Region Coordinating Group would include representatives from the following divisions:

- Policy and Planning (chair);
- Health Care Facilities;
- Insured Professional Services;
- Community Health and Health Promotion;
- Mental Health Services; and
- Drug Dependency Services.

The Regional Coordinator (chief of staff) from the Cape Breton Regional Health Agency would also be a member of the group. In addition, staff from other departments would be included as appropriate (e.g. Community Services, Education).

To ensure effective coordination between the activities of the Department and the regions, close working relationships will be established between the personnel of the Department and the Regional Health Agencies. For this reason, rotation of Regional Health Agency staff within the Department is proposed. These links should be fostered through regular contact with Department staff.

The Department of Health will create and chair a Regional Health Agency Planning Committee, to be comprised of the chairpersons of the six Regional Health Agency boards and senior Department staff.

The Policy and Planning Division will provide the secretariat for this committee. This committee will: provide a forum for the Department to consult the Regional Health Agencies as a group on other matters of common concern (e.g. province-wide health service standards); allow the Regional Agencies to voice their collective concerns to Department representatives; allow the Regional Agencies to share ideas and experiences with each other; and develop parameters for evaluating the impact of regionalization.

(d) Planning for Insured Services

As the Royal Commission on Health Care pointed out in its Report, Maritime Medical Care Inc. (MMC) has over the years conducted much research and policy analysis related to current and potential insured services programmes. MMC has frequently been a policy advisor to Government, and not simply an administrator of the MSI plan.

Development of public policy is properly a governmental responsibility. For this reason, and to ensure that research and analysis related to MSI programs is integrated with other Department of Health research and analysis, Government accepts the Royal Commission's recommendation with respect to MMC:

The Agreement with MMC will be amended so that the Department of Health will assume responsibility for research and policy analysis with respect to MSI programmes.

Corporate Services Division

The Corporate Services Division will amalgamate several functions currently provided in three separate divisions: Finance; Systems, Research & Planning; and Personnel. The Corporate Services Division's units will have responsibility for information systems, finance and personnel services for all divisions, and will act as a resource to them. It will also provide support, as required, to the Regional Health Agencies.

As detailed in Appendix V, the Division's **information systems unit** will assume a major role in systems development related to the MSI plan. Vital Statistics will also be included under the unit.

The Agreement with Maritime Medical Care Inc. (MMC) will be amended so that the Department of Health will assume a major role in systems development with respect to MSI programmes.

The major change to the **finance unit** will be its strengthened role in financial planning, forecasting, analysis and resource allocation. Better integration between finance, policy & planning, and information systems must be achieved in order to more effectively link financial planning with strategic planning.

Services to develop and manage the Department's human resources will be a major addition to the functions of the **personnel unit**.

The specific responsibilities of the Division's three units are detailed in Appendix V.

Health Care Facilities Division

This division will be responsible for the following types of health services offered to the Nova Scotia population:

- acute care;
- rehabilitative/restorative care;
- continuing care (in coordination with Department of Community Services); and
- primary health care offered in community health centres.

Each of these types of services may be provided in one or more of the following settings: institutions (teaching, regional or community hospital — on an inpatient or outpatient basis); community facilities (e.g. clinic, community health centre); or the patient's home. The Health Facilities Division will ultimately be responsible for services provided in all these settings.

The major change to this division will be a change of focus from institutions to a broader perspective which includes community-based health care services.

This division will be comprised of three units: a **construction and maintenance** unit (responsible for facility renovation and construction), a **consulting services** unit (key programme areas such as Nursing, Medical, Dietetics, Continuing Care, Purchasing, Pharmacy, Laboratory, Radiology), and a **regional operations** unit (responsible for all services offered regionally). (See Appendix V).

Insured Professional Services Division

(a) HSIC/Department of Health Integration

At present, the Health Services and Insurance Commission (HSIC) is responsible for overseeing the Medical Services Insurance plan (MSI). (For a description of the plan, and further details about HSIC's functions, see Appendix IV.) To ensure that policymaking with respect to insured health services is fully integrated with overall Department of Health policy and planning, the Royal Commission Report strongly recommended the merger of HSIC with the Department. Government accepts the Royal Commission's recommendation.

The Health Services and Insurance Commission (HSIC) will be integrated with the Department of Health, becoming the Insured Professional Services Division.

(b) Committees

Responsibility for several functions currently being carried out by the Health Services and Insurance Commission and its committees will be allocated to committees to be appointed by the Minister of Health. These functions are: the negotiation and interpretation of tariffs for providers; the due inquiry process; and the consideration of beneficiary and provider appeals regarding the eligibility of services for inclusion under MSI.

The following committees will be established by the Minister of Health: a Negotiating Committee, a Due Inquiry Committee, and an Insured Services Appeal Board.

Details concerning these committees are found in Appendix IV.

Community Health and Health Promotion Division

The Community Health and Health Promotion Division (CHHPD) will be responsible for the development, delivery and evaluation of programmes, standards and guidelines for health promotion and disease prevention.

Under the departmental reorganization, the radiation, public health inspection and engineering services of the existing Community Health Services Division will be subsumed by a new environmental health unit in CHHPD. The health promotion unit within the Division will play a support and resource role for the Department, ensuring that health promotion is central to all operations of the Department.

The Regional Health Units will implement the programmes, standards and guidelines developed by the central office of CHHPD. To accommodate regional needs, the Regional Health Units will have some flexibility in the use of their resources so as to develop regional programmes. In determination of regional health needs, the Regional Health Units will work closely with the Regional Health Agencies.

The Community Health and Health Promotion Division, through central office planning and regional office delivery, will provide health promotion, disease prevention, environmental health and community health nursing services. In addition, the Coordinated Home Care Programme will continue to be administered by CHHPD until an evaluation is completed.

Currently, the budget of the Community Health Services Division (excluding funds for the Coordinated Home Care Programme) accounts for approximately two per cent of the global Department of Health budget. A gradual reallocation of funds from acute care (hospital and physicians' services) will provide for the development and implementation of more comprehensive disease prevention and health promotion programmes. (See Chapter III for details).

Mental Health Services Division

This Division will be responsible for the development, coordination and administration of comprehensive mental health services on a regional basis. Changes planned for this division include better integration with other departmental programme areas and an increased emphasis on community mental health.

The current emphasis on acute care/treatment will be adjusted in favour of other components of the continuum of care, such as mental health promotion, education, disease prevention, and rehabilitation. (See Chapter III, Part 5 for details).

The division will be made up of three units: child and adolescent services; adult psychiatric services; and community mental health. The units' responsibilities are described in Appendix V.

Drug Dependency Services Division

Drug dependency services are one component of the continuum of care. The Royal Commission recommended that the existing Commission on Drug Dependency (CODD) become a division of the Department of Health. Government accepts this recommendation.

To ensure that drug dependency services are fully integrated with other health services, the Commission on Drug Dependency will be integrated with the Department of Health, becoming the Drug Dependency Services Division.

(a) Structure and Mandate

The Drug Dependency Services Division will be comprised of the following units: regional operations; prevention and community education; adolescent programmes; treatment and rehabilitation; pharmacology; and employee assistance programmes (see Appendix V for details).

The mandate of the Drug Dependency Services Division (DDSD) will overlap the mandates of several other divisions: Mental Health Services, Health Care Facilities and Community Health & Health Promotion. Therefore, the activities of the DDSD will be coordinated with these other divisions, as well as be attuned to the Provincial Health Goals and the Comprehensive Health Policy. The spirit of the Drug Dependency Act will be retained.

(b) Minister's Advisory Committee

The provincial advisory functions hitherto provided by the Commission on Drug Dependency will be maintained, by establishing a Minister's Advisory Committee on Substance Abuse.

(c) Regional Advisory Functions

The strong regional network of CODD will be maintained. The current CODD Regional Advisory Boards will report to the new Regional Health Agencies.

(d) Bequests

Bequests or trust funds created as gifts to the CODD will be maintained in a separate account in the Department of Finance, for exclusive use by the DDSD.

(e) Physical Facilities

The Royal Commission on Health Care noted that some of the physical facilities currently used by the CODD are inadequate. It was recommended that resources be allocated for the improvement of these physical facilities. To address this issue in the Metro area, the relocation of the programmes now offered by CODD at the Nova Scotia Hospital to a facility such as the old Grace Maternity Hospital will be considered.

CHAPTER II
HEALTH PROFESSIONS

INTRODUCTION

In its review of health professions, the Royal Commission on Health Care focused on three main professional groups: nurses, physicians and the associate health professions. The Royal Commission recommended that a **comprehensive health human resource plan** be developed to ensure an optimal allocation of personnel, based on the population's health needs.

A comprehensive health human resource plan will require:

(a) participation of health professionals;

(b) improved information systems to support planning;

(c) measures of health needs and outcomes;

(d) further clarification of the roles of certain professional groups — including physicians, nurses and the rehabilitation disciplines; and

(e) a method of matching human resource requirements to national, provincial and community health needs.

The Royal Commission also highlighted the need to improve the worklife of health professionals and to promote personal and professional growth in the health professions.

In order to achieve the goals of comprehensive health human resource planning and worklife improvements, action-oriented task forces will be created to deal with two key health professions: nurses and physicians. Development of a comprehensive health human resource plan — involving the associate health professions as well as physicians, nurses and dentists — is a Government priority. Therefore, the mandate of the Nova Scotia Advisory Committee on Health Human Resources will be expanded to include matters relating to all health professions in Nova Scotia.

The Nova Scotia Royal Commission on Health Care emphasized the important role the nursing profession plays in Nova Scotia's health care system. The Commission recognized the need for nursing to adapt to the changing health care environment and recommended that Government meet the challenge of planning for the future of nursing in cooperation and consultation with the profession. Nursing human resource planning should be undertaken in the context of overall health human resources planning, and be driven by the evolving health care needs of the population.

In the February 22, 1990 Speech from the Throne, Government announced its intention to establish an action-oriented task force on nursing.

The Task Force on Nursing will be formed, and begin its work, as soon as possible.

Mandate

The Task Force on Nursing will advise the Minister of Health in four areas: human resource planning for nurses; nursing education; worklife/professional development issues; and innovative nursing projects.

The Task Force will provide a forum where, through consultation and participation, Government and the nursing profession can develop solutions to issues facing nurses in Nova Scotia.

The Task Force on Nursing will report to the Minister of Health. The Task Force will maintain informational links with the Provincial Health Council.

The Task Force will not be research-oriented. The issues in nursing have been clearly identified by Government, the profession and academic research; **the Task Force will constitute the next phase of the change process, by developing an implementation strategy for nursing policy in Nova Scotia.**

Appendix VI provides details concerning the Task Force's terms of reference, membership, administrative support and sub-committees.

The Task Force will make its final report to the Minister of Health within **18-24 months** of its formation.

The Nova Scotia Royal Commission on Health Care acknowledged the pivotal role that physicians play in Nova Scotia's health care system. As the primary gatekeepers to insured health services, physicians to a large degree determine the use of other components of the health system — e.g. hospital care, diagnostic testing, specialists' services and prescription drugs — and thus significantly affect overall health care expenditure.

Expenditures on physicians' services have increased rapidly over the past two decades. Since 1970, physician expenditures per person have increased on average by 3.1% per year in constant dollar terms. Nova Scotia now ranks third (up from sixth in the early 1970s) among all provinces in per capita expenditure on physicians' services.

The rapid increase in physician expenditures reflects several factors: an increased supply of doctors; growth in per capita utilization of physicians' services; and fee increases.

(a) Physician Supply

Between 1970 and 1988, the supply of physicians in Nova Scotia increased by 88% (in full-time-equivalent terms). Nova Scotia's population increased by only 13% during the same period. The ratio of physicians to population is higher in Nova Scotia than in Canada as a whole.

(b) Utilization of Physicians' Services

Between 1981 and 1987, the number of physicians' services provided per 1,000 population in Nova Scotia increased for all types of services but two (home visits and hospital visits). The areas of strong growth (greater than 20%) included intensive care, psychiatric services, specialists' services, major surgery and office visits. Several factors have contributed to this growth — e.g. the general aging of the population, the development of new technologies, and changing medical practices to accommodate growing patient expectations and demand. However, not all of the growth in service provision can be adequately explained by these factors. Evidence to date suggests that the increased availability of physicians has been a major contributor to the increase in services provided.

It is important to note that increased expenditure on, and utilization of, physicians' services in Nova Scotia has not led to a high ranking in the health status of the population. For example, Nova Scotia has the highest rates of mortality and disability in Canada. While it would be unfair to expect physicians to assume the full responsibility for the failure of the general population to improve its relative health status in the past, it would be equally unreasonable to expect

that by simply continuing to increase the number of physicians we can achieve improvements to our health status in the future.

Despite national perceptions of an oversupply of physicians that have persisted for a decade, provinces have been reluctant to act unilaterally to reduce the growth in physician numbers because many of the factors influencing physician supply (medical school enrolments, immigration, licensure, Royal College standards, etc.) are directed by national policy. Furthermore, most provinces continue to struggle with geographic pockets of undersupply that still persist in rural areas. In view of this maldistribution of physicians, public concerns have arisen that reductions in the rate of growth of physician personnel will threaten the quality and availability of health care in some areas.

A major concern of health planners is that the methods of physician remuneration (dominated by fee-for-service) and practice organization (largely dominated by sole practice) both impede the efficient use of physician human resources to improve population health status. System financing and system organization are closely linked.

Growth in physician manpower must be more closely attuned to population needs, and expenditure on physician services must be effectively managed.

In view of the dramatic growth in physician expenditures and Nova Scotia's fiscal situation, it would appear inappropriate for Nova Scotia to continue to be one of the nation's leaders with regards to growth in physician numbers and the utilization of physician services. Given the long lead time required for physician human resource planning, the current growth rate in physician numbers and the concomitant rise in health care costs, it is critical that ameliorative action be initiated immediately.

The Royal Commission on Health Care recognized that, to assure equity of access and efficiency of expenditures, a strategy to manage the administration of physicians' services must involve a multi-faceted approach, consisting of policies on physician supply, distribution (professional and geographic), utilization and remuneration.

A managed growth strategy regarding expenditures on physicians' services will be developed. This Strategy will be based on the Royal Commission's Guiding Principles of public participation and regionalization, with particular emphasis on accountability, orientation to health outcomes and matching resources to health needs. The delivery of health services should emphasize a shift from acute, inpatient care to community-based care and reflect increased support of health maintenance, health promotion and illness prevention.

Service delivery goals and resultant health human resource requirements should be defined through a consensus approach. It is critical that a broad-based, consultative process be initiated involving Government, the public and the medical profession. Therefore,

A Ministerial Committee on Physician Policy will be formed, and begin its work as soon as possible.

Mandate

As outlined in the Throne Speech, the Minister of Health will invite the Medical Society of Nova Scotia to work with Government in developing a **Physician Human Resource Plan** for Nova Scotia.

The Ministerial Committee will provide a forum for physicians and Government to jointly develop strategies to meet the identified health service needs of the public in a cost-effective manner.

The Ministerial Committee is intended to be primarily a policy development body and not a research group. The primary issues with regard to physician human resources have been clearly identified by Government and confirmed by the Royal Commission on Health Care. The Committee is intended to be the next phase in the process of change, and as such, is expected to provide specific policy options to Government with regard to optimizing physician manpower supply and distribution and to managing growth in physician expenditures.

Details about the Ministerial Committee's terms of reference, membership and operations are found in Appendix VII.

Time Frame

The Ministerial Committee will present its final report to the Minister of Health within **12 months** of its formation.

PART 3: ASSOCIATE HEALTH PROFESSIONS

The associate health professions comprise more than 100 professional groups, such as physiotherapists, occupational therapists and audiologists. The proliferation of health professions in the past 20 years has posed many challenges for human resource planners. Competing claims for limited resources have underlined the importance of determining the appropriate mix of health personnel to meet the health needs of the public. Considering that health human resources comprise at least 70% of the total health care budget, the need for comprehensive planning of human resources is clear.

In its discussion of associate health professionals, the Royal Commission on Health Care identified supply and demand, education, recruitment and worklife issues as areas that should be addressed by Government and key stakeholders in the health system.

The Royal Commission, after examining the role of physicians and nurses in the Nova Scotia health system, stressed the urgent need to develop a comprehensive health human resource plan — including associate health professionals — to be based on health needs and the Provincial Health Goals. Such a plan will aim to ensure the efficient and effective allocation of health human resources.

As a part of the comprehensive human resource plan, the Royal Commission also recommended the development of training programmes for auxiliary personnel in rehabilitation services to further increase the efficient use of health resources.

In response to the Royal Commission's recommendations, the following initiatives will be undertaken:

A comprehensive health human resource management information system will be developed by the Department of Health, in consultation with the health professions.

The development of this information system represents the first phase in the development of a comprehensive human resource plan. The system will contain data on supply, production, distribution, demand (vacancy/turnover) and demographics of the various health disciplines in Nova Scotia.

Currently, the mandate of the Nova Scotia Advisory Commission on Health Human Resources excludes matters pertaining to physicians, nurses and dentists. The work of the committee includes the monitoring of the supply, distribution, production and demand for health professionals in Nova Scotia. The Committee acts in an advisory capacity to the Minister of Health and Fitness.

Through Sub-Committees, specific health disciplines are studied in detail on a variety of issues ranging from supply and demand, distribution and production to broader worklife issues.

The mandate of the Nova Scotia Advisory Commission on Health Human Resources will be expanded to include matters pertaining to all health professions in Nova Scotia.

CHAPTER III
REVITALIZED SERVICES FOR THE CONTINUUM OF CARE

INTRODUCTION

Between 1984-85 and 1989-90, total Provincial Government spending on health[1] increased by an average of 7.9% per annum, well above the 6.2% growth rate for overall Provincial Government spending (see Appendix I). In 1990-91, total health expenditures are estimated at $1.27 billion. Health spending is the single largest component of the provincial budget.

High levels of health expenditure in Nova Scotia have not been associated with good health outcomes: as we have seen earlier in this Report, health status indicators for the province's population are poor in comparison with national figures. The vast majority of governmental health care expenditures is directed towards hospital operating costs and the cost of physicians' services: in 1989-90, 84% of the budget of the Department of Health and Fitness was spent in these two areas alone. In contrast, community health programmes — which include all disease prevention and health promotion activities — received only 2.2% of the Department's budget.

The Nova Scotia Royal Commission on Health Care recommended a fundamental re-orientation of the health system. A comprehensive approach to health and health care, involving increased coordination and integration of health services, was called for, with the emphasis shifted as follows:

- from the acute/curative components of the health services continuum to disease prevention and health promotion;
- from inpatient institutional care to community-based care, wherein patients remain in their communities and homes; and
- to user participation in planning health services.

1. Total Provincial Government spending on health is comprised of: (i) all expenditures of the Department of Health and Fitness ($1.1 billion in 1989-90); and (ii) health-related expenditures of the Department of Community Services ($110 million in 1989-90).

In light of the above, Government will implement the following measure:

Spending on community health programmes, including health promotion, will be increased from 2.2% of the Department of Health budget to approximately 4% within five years. This will be achieved by internal reallocation within the Department's overall budget.

For the past 10 years Provincial Government health expenditures have consistently increased faster than the total Provincial budget, and they now account for almost 30 cents of every dollar spent by the Government of Nova Scotia. If action to limit this rapid increase in spending is not initiated, health care will continue to consume an ever-larger share of the provincial budget. This would leave fewer resources available for other vital economic and social programmes that also enhance health — economic development and environmental protection, for example.

The health care budget will be managed more efficiently, to ensure that health care expenditures do not consume an inordinate share of the total Provincial Government budget.

The rate of increase of total Provincial Government spending on health will be reduced.

This chapter presents a strategy for the revitalization of health care services. The organization of the chapter reflects the continuum of care. Included are sections on Primary Health Care, Community Health, Acute Care and Continuing Care. Several programme areas that transcend the boundaries of the above services are then discussed in separate sections. These are Mental Health Services, Drug Dependency Services, Ambulance Services and Pharmacare.

PART I: PRIMARY HEALTH CARE DELIVERY

During the past two decades, the major focus of the province's health care planning and spending has been the establishment of a system of modern, accessible hospitals. In particular, the province has put in place a network of referral services, at tertiary and regional/secondary hospitals. The aim has been to provide access to specialty medical care throughout Nova Scotia.

During the decade that lies ahead, increased emphasis will be placed on Primary Health Care. **Primary Health Care** is the first level of contact of the public with the health system. It includes treatment services as well as health promotion and

disease prevention, all focused on the main health problems of the community. It provides services which are accessible, acceptable and affordable, and is based on significant community participation.[2]

Separately, the components of Primary Health Care have been integral parts of the health care system in Nova Scotia. Physicians' services are widely accessible in most areas of the province. Rehabilitative and restorative care have been developed. Health promotion and disease prevention services have been delivered to residents through Regional Health Units and other community provider agencies. However, the greatest emphasis of the health care system has been on the treatment components, and delivery of all health services has been fragmented and uncoordinated.

The challenge to both government and non-governmental agencies providing health-related programmes is to deliver these services in ways that can best meet needs at a local level, and to integrate these services as part of a regionalized approach. Part of this challenge is to encourage health promotion and build better understanding of personal responsibility for health and health care.

Primary Health Care will be adopted as a guiding principle for the provision of health services in Nova Scotia. A population-based approach, which attempts to better match resources to needs, will be promoted using the most appropriate providers for the care given. A primary health care approach can allow the focus of the health care system to move from illness and cure to health and prevention. This does not mean that treatment is separate or less valuable; instead, it will constitute one component of a comprehensive approach to the health of the individual.

The Government of Nova Scotia will promote the Primary Health Care approach in all regions of the province. The Department of Health will integrate Primary Health Care principles into its departmental Strategic Plan.

Working Group on Primary Health Care Delivery

The consultation processes undertaken both by the Royal Commission on Health Care and by the Minister of Health have demonstrated a growing readiness of communities to adopt a new approach to delivery of health care. This approach would focus on integrated and coordinated strategies for the provision of Primary Health Care services.

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2. Adapted from **The Declaration of Alma-Ata: Primary Health Care is the Key for All.** (World Health Organization, 1978).

The Department of Health will set up a Working Group on Primary Health Care Delivery to help communities develop integrated approaches to primary health care. The Working Group will work in consultation with other departments and agencies involved in related service delivery.

Numerous initiatives have been proposed and implemented in other jurisdictions to deliver primary health care in an improved manner. These include experimentation with alternative forms of delivery (e.g. community health centres and health services organizations) and better integration of various components of the continuum of care (e.g. nursing homes integrated with community hospitals). The Working group on Primary Health Care Delivery will review these initiatives and help develop approaches appropriate to Nova Scotia's health care system.

The Working Group on Primary Health Care Delivery will oversee the design and evaluation of models of health care delivery that promote a change of philosophy to primary health care, with emphasis on integrated prevention, promotion, and treatment services delivered to individuals in their communities.

The Working Group will oversee pilot projects aimed at improving the match of health resources to local needs. Approved projects will demonstrate anticipated beneficial impact on health and cost-effectiveness through resource reallocation and innovative use of existing community and regional resources. The Working Group will not finance the implementation of projects; its budget will be used to assist with project design and to fund project evaluations.

Implementation of pilot projects will foster local and regional integration of health related services (including enhancement of community cooperation and development) and intra and inter-departmental coordination.

Details of the Working Group on Primary Health Care Delivery's objectives, terms of reference, membership and administrative arrangements are found in Appendix VIII.

PART 2: COMMUNITY HEALTH AND HEALTH PROMOTION

Health protection, disease prevention and health promotion constitute the traditional mandate of public health and community health, whose services are oriented to the maintenance or enhancement of the health of persons living in a defined community.

Until 1988, the activities of the Community Health Services Division — which will be renamed the Community Health and Health Promotion Division (CHHPD) under the Department of Health reorganization — were in general health protection and disease prevention. In 1988, the scope of the division broadened with the establishment of formal health promotion services. Also in 1988, a new interdepartmental, intersectoral community-based programme providing home care was developed. Given the existing organization of the Department of Health and Fitness, the administration of the health component of the Home Care Programme was located in the Community Health Services Division. In this manner, the division came to assume an unusual responsibility — the provision of actual treatment services.

The formal adoption of the Guiding Principles recommended by the Royal Commission will have a significant impact on the Community Health and Health Promotion Division. The impact will be fourfold:

Firstly, attaining a better balance between the curative and preventive components of the health system will represent a major change in focus for the Department of Health. An essential initial step towards this change is the elucidation of Health Goals. The expertise of CHHPD will be invaluable in providing sound methodology for the establishment of these Goals and subsequent evaluation of their attainment. The Health Goals will form the basis of a health promotion model recognized as an integral part of the Department's long-term strategy. The natural evolution will then be towards the establishment of a Comprehensive Health Policy, sensitive to the changing needs of our population.

The development of Health Goals, a health promotion model and a Comprehensive Health Policy, cannot be achieved in isolation. There must be collaboration among all the divisions of the Department, the Provincial Health Council, Regional Health Agencies, and other Departments which have an impact on health in the broad sense. Clearly, the process will require commitment, patience, and vision on the part of all those involved.

Secondly, the matching of scarce resources to these newly-defined needs will necessitate the reallocation of funds. The Department's financial commitment to date has been largely directed towards acute care; health promotion and disease prevention programmes account for only about 2% of the Department's 1990-91 budget. Initiating the reallocation process requires leadership and a strong commitment to new priorities, including a change in focus from health care to health.

As stated in the Introduction to this chapter, spending on community health activities will be increased over the next five years: the target is to increase the share of the Department of Health budget devoted to community health (excluding home care, which is a treatment programme) to 4% of total departmental

spending. These funds will be channelled into development, implementation and evaluation of comprehensive health promotion and disease prevention programmes.

The Community Health Promotion Fund (CHPF) was announced in the February, 1990 Speech from the Throne. The Fund will finance health promotion and illness prevention projects at the community level. Funding during the first year will be $225,000.

Thirdly, regionalization of health planning and services will entail some restructuring of the geographic boundaries of the present regional Health Units. More important, however, is the redefinition of the roles of CHHPD central office and the Health Units.

The expertise of CHHPD central office will be channelled into the development and periodic evaluation of core programmes, guidelines and standards. The CHHPD consultants will also be active participants in the development and periodic evaluation of Provincial Health Goals and act as resource persons for the Health Units.

The Health Units will be responsible for the implementation and functioning of core programmes, guidelines and standards devised by CHHPD central office. Each Health Unit must be sensitive to regional needs and work in close liaison with the Regional Health Agency. The degree of responsibility assumed by the Health Unit team and Director, especially regarding the health planning function, will influence their ability to effectively participate in the Regional Health Agency.

A balance between differing regional priorities and standard province-wide concerns must be attained. Essential province-wide programmes (e.g. immunization programmes), guidelines and standards — and the required resources — will be pre-determined periodically by CHHPD central office, but a percentage of Health Unit resources will comprise discretionary funds allocated by the Health Unit to reflect regional uniqueness. **It is intended that initially 20% of a Health Unit's resources be discretionary.** A committee with joint participation by CHHPD central office and Health Units will review proposals from the Health Units and address the distinctive nature of the regions. This committee will also periodically review the discretionary percentage and the designation of essential programmes.

A committee with joint participation by Community Health and Health Promotion Division central office and Regional Health Units will be established to maintain definition of their respective priorities, roles and objectives.

Traditionally, the Department of Health's epidemiology expertise has been provided by an epidemiologist in the Community Health Services Division. Under the planned reorganization of the Department of Health, the epidemiology function at headquarters will be assumed by the Policy and Planning Division. It will provide epidemiological support and analysis to all parts of the Department, and to the new Regional Health Agencies. As Health Unit Directors become more involved in regional health planning and evaluation, some epidemiology functions will be assumed regionally.

Fourthly, there will be some overlap between the domain of CHHPD and those of other divisions of the Department of Health. Many of these will be addressed in the course of the development of Provincial Health Goals. One is of immediate concern.

Both CHHPD and the Drug Dependency Services Division are concerned with the morbidity associated with substance abuse, and both divisions emphasize public education as an important means of prevention. Substance abuse and several infectious diseases (e.g. hepatitis B) are linked through high-risk behaviours. Communication between these two divisions will be strengthened, and the sharing of expertise encouraged. The goal will be to achieve comprehensive, coordinated risk-reduction and immunization strategies for the prevention of disease.

PART 3: ACUTE CARE

Historically, most health care resources have been invested in the acute care sector, principally in hospital services. The new **Health Strategy** argues that significant improvements in health can result from greater emphasis and expenditure on health promotion, illness prevention, rehabilitation and restorative care. Furthermore, the health needs of an aging population such as exists in Nova Scotia will increasingly demand continuing care (long-term care) programmes.

The Royal Commission on Health Care recommended a reallocation of resources from the institutionally-based acute care sector to other services and programmes, including health promotion. Reallocation will be made possible as this sector continues to introduce efficiencies in the delivery of acute care.

Nova Scotia has traditionally spent a comparatively large proportion of health care dollars on hospitals (47% as of 1985, versus the national average of 44%). The Royal Commission noted that a national trend towards decreased expenditure on hospital services and corresponding increases on other types of institutions, such as homes for the aged and for the mentally and physically disabled, was not as evident in Nova Scotia.

Rationalization of the hospital sector has been initiated by the Department of Health, and will be continued.

Areas of rationalization include:

- **Regional services planning.** The roles of hospitals in a number of regions are being clarified and differentiated, resulting in less duplication of services. With the proposed regionalization of health services, planning for acute care services will become part of overall regional health planning.

- **Regional Health Human Resource Planning.** Regional planning for services of hospital-based specialist physicians has been successfully initiated in all regions of Nova Scotia. This exercise will be continued as part of the regional planning process.

- **Decrease in inpatient utilization and increase in community-based programmes.** This shift has been initiated, and experience in other provinces suggests there is potential for further rationalization, leading to reduced costs, and benefits for patient care.

- **Changing the focus of the community hospital.** The Department of Health is currently examining changing the focus of small community hospitals to community health centres or multi-service centres. This shift in focus will be further strengthened, through working with communities to foster the goal of Primary Health Care. The role of hospital trustees in supporting such a shift is central — **trustee and public education will be necessary to assist in changing the focus of community hospitals.** The proposed Working Group on Primary Health Care Delivery and primary health care pilot projects will be useful in further developing this approach.

- **Integrated and combined services between hospitals and nursing homes.** The Department of Health has begun reducing duplication in administration and service provision (e.g. kitchen and laundry facilities) between acute care and long-term care institutions in several areas of the province (e.g. Canso, Guysborough, Eastern Shore). This type of rationalization will continue to be implemented wherever appropriate. In addition, the use of "swing beds" in community hospitals (beds that "swing" among Level II-V care in accordance with patients' needs) will be promoted as needed.

- **More effective management.** Further rationalization of acute care services through better management at the institutional, regional and provincial levels must be achieved. Enhanced management includes:

- professional development of managers working in administrative positions;
- improved health information systems and planning resources (including the national Management Information Systems Project to improve MIS in health care facilities); health human resource planning; evaluation; impact analysis; and demographic, epidemiological, and financial information;
- review of funding administration and financial incentives;
- strengthening Departmental consultants' roles and making them more applicable to the needs of hospitals and other health care services;
- enhanced Departmental management of physician utilization; and
- a revised funding cycle (minimum three years) to enable longer term planning of services by regions and institutions.

PART 4: CONTINUING CARE

Scope of Continuing Care

Continuing care is distinct from acute care which is aimed at curing episodic illness. Continuing care deals with chronic illness or disability, and the main focus is on maintenance of the patient's health status and quality of life. A person may move back and forth among several types of continuing care over a period of time, as his/her health care and social needs change.

Continuing care includes the following services from the continuum of care:

(i) The services provided by the Coordinated Home Care Programme (CHCP). The CHCP currently offers homemakers' services and basic in-home nursing care (treatment) to three specified target groups: persons over 65 years of age, disabled persons and families at risk. Overall responsibility for the CHCP rests with the Home Care Coordinating Agency, whose membership consists of the Ministers and Deputy Ministers of Community Services, Health, Housing and Municipal Affairs, and the Chairman and the Chief Administrative Officer of the Senior Citizens' Secretariat.

(ii) The personal care and nursing services provided by the following facilities, which are administered by the Department of Community Services and included under the umbrella term 'Homes for Special Care' (see Glossary of Terms for specific definitions):

- Nursing Homes
- Homes for the Aged

- Developmental Residences
- Group Homes
- Adult Residential Centres
- Regional Rehabilitation Centres

(iii) Level III care — Level III care consists of personal care, nursing and medical care. It is currently provided in Department of Veterans' Affairs facilities and in acute-care hospitals;

(iv) "Swing beds" — hospital beds, especially in smaller community hospitals, for which the level of care "swings" among Levels II-V;

(v) Geriatric programmes — geriatric day hospitals, geriatric assessment units, geriatric rehabilitation units and similar programmes;

(vi) Supportive Care (care intended to provide support rather than cure or rehabilitation), including palliative care, respite care, day care and night care. This care can be provided in hospitals, Homes for Special Care or individuals' homes.

Target Groups

The main groups in need of continuing care services are the elderly, the terminally ill, the disabled, and children with chronic health care needs.

Strategy

Responsibility for continuing care services is currently spread among several government departments (Community Services and Health in particular). Improved coordination and integration of these services is necessary if consumers are to receive comprehensive, high-quality care.

The management of continuing care services will be strengthened.

Strengthening the management of continuing care is intended to achieve the following objectives:

(a) Ensure that persons in need of continuing care services receive the appropriate service in a timely manner, and to the greatest extent possible, in the home or on an outpatient basis;

(b) Increase coordination among departments involved in continuing care, notably the Departments of Health and Community Services;

(c) Ensure that continuing care services are provided in a cost-effective manner.

To achieve these objectives, the following specific measures will be taken:

1. **The Home Care Coordinating Agency will be renamed the Continuing Care Coordinating Agency and its mandate will be broadened to include all continuing care services (including the Coordinated Home Care Programme). The Continuing Care Coordinating Agency will provide policy direction and leadership. It will work in close consultation with Regional Health Agencies in meeting the mandate of coordinating continuing care services at the regional level.**

2. **The possibility of establishing a single entry point for all continuing care services in each area of the province will be examined. These entry points would operate according to provincial standards and guidelines to be established under the auspices of the Continuing Care Coordinating Agency.**

3. **Within the Community Health and Health Promotion Division of the Department of Health, separation of the CHCP nursing-care component from the community health nursing function (health promotion and disease prevention) will be instituted.**

4. **An evaluation of the Coordinated Home Care Programme (CHCP) will be completed. After this evaluation is complete, the desirability of expanding the CHCP to include additional services and/or target groups will be examined. In addition, the question of which division within the Department of Health should administer the CHCP will be reviewed. (Home Care is a treatment programme, and as such should eventually be administered by the Facilities Division, which has responsibility for treatment services.)**

5. **A review of Level III care will be undertaken, in particular to determine if providing Level III care in Nursing Homes would be more appropriate and/or less costly than providing it in hospitals.**

In 1972, a Department of Health brief on mental health services[3] recognized the lack of availability of inpatient psychiatric care in many regions of Nova Scotia. Reorganization of mental health services was recommended and is now nearing completion. The redistribution of services will result in the availability of in-patient, out-patient and partial hospitalization services in all regional hospitals.

The current concerns in mental health services are fourfold.

Firstly, the Nova Scotia mental health system focuses on mental health care rather than mental health. Seventy-eight percent of the mental health services budget supports in-patient treatment. Prevention, education and mental health promotion have received comparatively little emphasis.

Secondly, the emphasis given to in-patient mental health care services since 1972 may have inadvertently undermined alternative modalities for the delivery of treatment. Community-based programmes now need to be developed and enhanced. These programmes include out-patient care, home care, half-way houses, foster homes, group living, sheltered workshops, placement and outreach services.

Thirdly, the measures adopted to ensure an equitable distribution of treatment services in all regions may have been only partially successful and will be reviewed. At present, the Nova Scotia Hospital is allocated fifty-two percent of the mental health budget. Although this hospital provides all levels of mental health care and is located in the province's largest urban centre, its share of the budget may be disproportionately high.

Fourthly, community involvement in mental health may have been compromised by the 1976 amalgamation with general hospitals. The Regional Mental Health Advisory Committees may have been hampered by the lack of a clear mandate and by weak enforcement of legislation.

The Guiding Principles put forward by the Royal Commission provide a framework to address these concerns. Mental health professionals and community members will participate in the development of Provincial Health Goals and a Comprehensive Health Policy. These long-term plans will underline the importance of mental health as well as mental health care in the continuum of services.

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3. Townsend FR,1972. "Brief on psychiatric community mental health services. Plan for the reorganization of the psychiatric services delivery system". Nova Scotia Department of Public Health.

Integration and coordination with all the divisions of the Department of Health will promote the reallocation of resources from in-patient care to community-based programmes. The Regional Mental Health Advisory Committees will become sub-committees of the new Regional Health Agencies. Thus, community participation and regionalization of mental health services and planning will be improved.

Programme Priorities

A Working Group on Mental Health Services will be set up to review and set up a strategic framework for mental health services in Nova Scotia. Several programme areas have been identified as priorities, and are discussed in this section. These include Child and Adolescent Services, Psychiatric Rehabilitation, Forensic Psychiatric Services, and programmes to deal with societal violence.

(a) Child and Adolescent Services

Children and adolescents as a population have unique mental health problems. Their special mental health needs have led to the development of the subspecialty of child psychiatry and to alternative settings for the delivery of services.

For example, a crisis residential centre provides short-term shelter and guidance for children with psychosocial problems. Assessment services concerning placement and/or psychiatric treatment are also available in that setting. The Departments of Health and Community Services have established three such regionally-based centres, as a result of the increased number of cases of psychosocial crisis among youth.

Twenty-five to 30 percent of all out-patient referrals for mental health care concern children and adolescents. The child in crisis requires immediate care, yet waiting lists for child psychiatrists may be as long as three to six months. The lack of availability of timely psychiatric care tends to compound the problems of an already vulnerable population.

In 1988 and 1989, the Departments of Community Services and Health and Fitness appointed Co-Directors of Child and Adolescent Services. A regionalized plan for children's and adolescents' mental health is being developed. Assessment services, standardized admission criteria, management of emergency cases, a review of clinical resources and specialized foster home programmes are included.

Child and adolescent services available through the Izaak Walton Killam Hospital, the Nova Scotia Hospital and the Atlantic Child Guidance Centre are being integrated and coordinated.

(b) Psychiatric Rehabilitation

Long-term care and disability management of the psychiatric patient is an ongoing priority. Various levels of mental health care are required. Care ranges from long-term hospitalization to community-living with periodic re-admissions. Many de-institutionalized patients require special housing and clinical rehabilitation services.

The continuum of care should be improved by the integration and coordination of programmes offered by the Departments of Health and Community Services. Mental health care planning may involve partial hospitalization and such community-based services as home care, group homes, homes for special care, nursing homes, and alternative living arrangements.

Partial hospitalization offers more intensive care than can be provided in an out-patient department. Standardized partial hospitalization programmes for assessment, treatment and rehabilitation need to be developed and evaluated.

(c) Forensic Psychiatric Services

Youth Programmes:

At present, psychiatric assessment of young offenders is carried out on an in-patient basis by a multi-disciplinary team at the Nova Scotia Hospital. This service may occasionally be more appropriately provided on an out-patient basis.

The Outpatient Community Services Assessment Programme has been introduced as a pilot project. Attached to the Atlantic Child Guidance Centre, the programme is based on the "court clinic" concept. The comprehensive services include:

- court related assessments for protection services under the Children's Services Act and assessments under the Young Offenders Act;
- non-court related assessments to determine the need for treatment or appropriateness of a placement in the care of specified community service agencies.

Adult Programmes:

The nine provincial correctional centres, under the aegis of the Solicitor General's Department, have a capacity of 492 inmates. The average daily occupancy rate during 1989-90 was 81 percent.

It is estimated that twenty percent of inmates have a mental disorder. The Forensic Unit of the Nova Scotia Hospital accommodates the majority of psychiatric remands and referrals from the provincial correctional centres. The eighteen-bed Unit is consistently overcrowded. Programme development and evaluation are severely limited.

Changes in the Child Welfare Act and in Canada's Criminal Code are expected to result in an increased demand for forensic psychiatric care services. Clearly, close coordination between the Departments of Health, Community Services and the Solicitor General is required to improve mental health services to the incarcerated population.

(d) Programmes to Deal with Societal Violence

Through the efforts of numerous segments of our society, family violence and sexual abuse have become recognized as urgent problems. The demand for mental health services related to societal violence is increasing. Clients may be self-referred, referred by courts or by family and children's services.

The Departments of Health, Community Services and the Attorney General plan to cooperate in the development of a programme to deal with societal violence. The actual mental health care will be the mandate of the Mental Health Service Division. Additional staff and staff education are essential for Mental Health Services Division to meet these needs.

Organizational Issues

(a) Nova Scotia Hospital

The role of the Nova Scotia Hospital will be redefined as a result of: (1) a role review of the hospital currently being conducted by a consulting firm; (2) plans for the construction of a new in-patient facility on the hospital grounds; and (3) measures to make the hospital into an independent corporation. As recommended by the Nova Scotia Royal Commission on Health Care,

The Nova Scotia Hospital will become an independent corporation, subject to the same rules and regulations as other hospitals in the province.

These changes, together with regionalization of health planning and services, will have a major impact on utilization of primary and secondary levels of care at the Nova Scotia Hospital, making the development of a Provincial Mental Health Services Plan all the more urgent.

(b) Liaison services

The long-term management of patients with both mental and physical illness is often complex. Communication among professionals and institutions providing medical and mental health care may become problematic. Mechanisms for liaison need to be developed and strengthened.

(c) Mental Health Human Resources

Mental health care is provided by psychiatrists, community mental health nurses, clinical psychologists, social workers and occupational therapists. For more than a decade, there has been a shortage of mental health professionals in Nova Scotia and throughout Canada.

The shortage of psychiatrists has been a highly visible problem. However, all mental health professions are faced with shortages resulting from similar factors, including:

- an increased demand due to changing public and professional attitudes to mental health;
- the continued development of sub-specialties in psychiatry;
- the aging of the population;
- the geographic maldistribution of health professionals;
- the de-institutionalization of the chronically mentally ill; and,
- the concentration of psychiatrists in private practice rather than in public psychiatry.

The shift in emphasis from in-patient to community-based care and from mental health care to mental health will require close cooperation among mental health and other health professionals. The development of mental health teams regionally may also help alleviate the shortage of psychiatrists. Recruitment, training opportunities and work conditions for the mental health professions need to be examined and ameliorated.

Review of Mental Health Issues

A Working Group on Mental Health Services will be established by the Minister of Health.

This Working Group will conduct a comprehensive review of mental health services in Nova Scotia, and establish strategic directions for the system. In consultation with providers and consumers, the Working Group will develop a Provincial Mental Health Services Plan. The plan will be made available to Government, providers and consumers. The Working Group's membership, timeframe and administration are outlined in Appendix IX.

PART 6: DRUG DEPENDENCY SERVICES

Substance abuse, in general, is a covert activity with potential legal and socioeconomic repercussions in addition to health implications. The nature of substance abuse imposes limitations on many aspects of diagnosis, treatment, rehabilitation and research. The scientific literature emphasizes that successful programmes depend on the use of a non-judgemental, culturally-sensitive approach stressing confidentiality.

From its inception in 1972, the operational organization of the Nova Scotia Commission on Drug Dependency (CODD) has reflected the nature of substance abuse and drug dependency. The principles of matching resources to needs, regionalization, and participation of citizens are the basis for programme development and service delivery. Many programmes focus on prevention, through public education.

The Royal Commission commended the CODD for its approach. CODD's network of Regional Advisory Boards, and coordination within the CODD, can serve as a model for the restructured Department of Health. Because drug dependency services are one component of an integrated health strategy, the CODD will be integrated into the reorganized Department of Health as the Drug Dependency Services Division (DDSD).

An understanding of the societal problem of drug dependency will be an important contribution by the DDSD in the development of Provincial Health Goals and a Comprehensive Health Policy. The Goals and Policy will provide a framework for decision-making. Close liaison between DDSD's Regional Advisory Boards and the new Regional Health Agencies will ensure rational health planning.

The functions of DDSD, adapted from the current Drug Dependency Act, will include:

- programmes for prevention, treatment and rehabilitation of persons with drug dependency problems;
- policy and research activities, in coordination with the Policy and Planning Division;
- coordination of drug dependency activities (among divisions, departments and provinces, or involving federal-provincial agreements); and
- administrative functions, in coordination with the Corporate Services Division.

These are described in Appendix V.

Organizational Issues

The CODD receives cost-sharing funds from Health and Welfare Canada. These funds have in recent years accounted for almost 40% of CODD's budget. Currently, of a total of 283 CODD positions, 197 positions, involving all levels and aspects of the activities of CODD, are cost-sharable.

Federal sources of funding include the Vocational Rehabilitation of Disabled Persons Agreement and the Alcohol and Drug Treatment Rehabilitation Agreement, as well as grants from the National Drug Strategy. The cost-sharing agreements are under the aegis of the Department of Community Services. The implications of a transfer of these monies from the CODD to DDSD have not yet been finalized. Interpretation of the cost-sharing agreements may have an impact on the operational organization of the DDSD, and will need to be carefully assessed.

PART 7: AMBULANCES

The Nova Scotia Government has operated an ambulance subsidy programme since 1970. Initially, this programme was administered by the Department of Social Services. It was later brought under the Department of Health, and in 1989 administration was assumed by the Health Services and Insurance Commission. Although there has been no legislation regulating ambulance services, there was an Ambulance Advisory Board which reported to the Minister of Health.

The Royal Commission on Health Care recommended dissolution of the Advisory Board. It identified the areas of operator training, equipment standards, and efficiency through coordination of services as priorities for review and policy development.

In 1990, the Ambulance Advisory Board was dissolved and the legislation was changed to allow the formation of a more broadly-based Ambulance Services Advisory Committee. (The membership of the Committee is described in Appendix X.)

The Ambulance Services Advisory Committee has determined priority areas for policy development. These are:

1. A mission statement to define programme goals and objectives.

2. **Draft of legislation and regulations for consideration by Government. Areas to be addressed include standards for ambulances and ambulance operators, conditions for entry to ambulance service, and general legislative guidelines for all ambulance service delivery.**

3. **Management information systems and automated claims processing.**

4. **Education and training. This would include:**
   - **the roles of the Ambulance Operators Association and government departments in the provision of training programmes; and**
   - **levels of training and the appropriate methods of training.**

5. **Standards and guidelines. This will include standards for vehicles, equipment, minimum training for ambulance operators and attendants, response time and communication equipment.**

6. **Service delivery. The effectiveness and efficiency of existing services will be evaluated. Alternative models for the delivery of service will be examined.**

7. **Pre-hospital care. The role of ambulances and ambulance operators in pre-hospital care will be defined. The role of paramedics, and staffing of hospital emergency out-patient departments to receive emergency patients, will be considered.**

Once the policy areas have been defined the committee will hold regional meetings to allow for public input.

Government supports the establishment and priorities of the Ambulance Services Advisory Committee, in keeping with the recommendation of the Nova Scotia Royal Commission on Health Care, and will promote enhanced management of ambulance services in Nova Scotia.

PART 8: PHARMACARE

Nova Scotia has provincial Pharmacare plans that cover prescription drugs for seniors (persons age 65 and over) and for disabled recipients of Family Benefits payments from the Department of Community Services. Both plans are currently administered by the Health Services and Insurance Commission.

(a) Pharmacare Issues

There is concern about **inappropriate utilization** of prescription and non-prescription drugs. This concern is especially pertinent for the seniors' and Community Services Pharmacare plans, where beneficiaries use an average of 25 prescriptions per year.

There have been rapid increases in **expenditure** for both the seniors' and Community Services Pharmacare plans. At present these programmes account for approximately $80 million in Government expenditure, which would double every four or five years at current rates of growth.

Proposals have been made to extend Pharmacare coverage to **uninsured persons** who face catastrophic drug expense, or to low income groups — for example, Family Benefits recipients who are not disabled.

A number of policy initiatives are currently underway to address the issues of drug utilization and expenditure:

- As of June 1, 1990, payment of drug cost is based on Maximum Allowable Cost, defined in terms of the lowest-price generic equivalent, for drugs listed in the Nova Scotia Prescription Drug Formulary. A co-pay ($3.00 per prescription) also became effective on June 1, 1990.

- A Benefits Evaluation Committee has been established to review drugs insured under the Pharmacare plans to determine if they should continue to be insured, based on therapeutic value and patterns of utilization.

- A drug utilization review process is planned to monitor and deal with over-utilization of drugs under Pharmacare plans. Benefits evaluation and drug utilization review will be the responsibility of the Insured Professional Services Division in the reorganized Department of Health.

- Efforts to establish a peer review process are underway. These include:
  - a triplicate prescription programme, which the Health Services and Insurance Commission has proposed to the Provincial Medical Board and offered to fund; and
  - review of prescriber profiles by the MSI Medical Review Committee.

- A research project designed to improve knowledge about drugs ("Seniors and Their Medicines") has been funded by the Nova Scotia Government (through the Centre for Health Care for the Elderly, Camp Hill Hospital) and the federal government.

Expansion of coverage to uninsured persons will not be feasible until mechanisms are in place to control the rate of growth of existing Pharmacare expenditures.

(b) Advisory Committee on Drug Utilization

In 1989, the Minister of Health invited key groups to participate in increasing public awareness and prescriber education about drug utilization. Virtually all groups indicated a desire to participate in such an effort.

A committee on seniors' drug utilization was announced in the February, 1990, Speech From the Throne. This committee will provide ongoing advice to the Minister of Health.

An Advisory Committee on Drug Utilization will be established.

The Advisory Committee will work closely with Government to achieve the following objectives:

- Make consumers/beneficiaries aware of the benefits of appropriate drug utilization and the hazards of inappropriate utilization.
- Encourage appropriate prescribing standards and control by prescribers. (A sub-committee on prescriber education will be set up.)
- Alert pharmacies of problems with drug utilization identified within the province's prescription drug plans; and encourage pharmacists to educate consumers about appropriate drug utilization.
- Seek to achieve consensus on future Government initiatives in the area of prescription drug usage, including coverage of drug expenses for uninsured persons.

Details about the Advisory Committee's membership and operations are found in Appendix XI.

Health Expenditures by the Government of Nova Scotia
1984/85 - 1989/90
($ Millions)

	1984/85	1985/86	1986/87	1987/88	1988/89	1989/90
Department of Health and Fitness *	$ 756	$ 813	$ 860	$ 927	$1,008	$1,096
Dept. of Community Services * **	69	72	75	79	90	110
Total Health Expenditures *	$ 825	$ 885	$ 935	$1,006	$1,098	$1,206
Total Provincial Expenditures *	$3,066	$3,206	$3,336	$3,545	$3,906	$4,150
Rate of Growth from Previous Year:						
Total Health Expenditures		7.3%	5.7%	7.6%	9.1%	9.8%
Total Provincial Expenditures		4.6%	4.1%	6.3%	10.2%	6.2%

* Includes Ordinary Expenditures (net of Recoveries) plus Capital Expenditures. Figures for 1989/90 are preliminary. Data sources:(a) 1984/85 - 1988/89, Public Accoounts; and (b) 1989/90, Estimates for the Fiscal Year 1990/91.

** Includes Homes for Special Care cost sharing; Homes for the Aged cost-sharing; services to the mentally retarded; provincial drug assistance; and payments to municipalities for administration of services.

PROVINCIAL HEALTH COUNCIL

Terms of Reference

The Provincial Health Council will:

- Advise the Executive Council, through the Minister of Health, on a Comprehensive Health Policy and recommend Health Goals for the Province. It will also provide advice on how these Goals will be achieved.

- Assess progress in achieving Health Goals, and publicize this progress through an Annual Report. Given the evolving nature of health care, the Council will redefine Goals and objectives on an ongoing basis, and assess health outcomes.

- Increase public participation in the development of a Comprehensive Health Policy for Nova Scotia through a consultative process.

- Increase public awareness and knowledge of health issues, including population health status, the cost of the health care system, and personal responsibility to improve health.

- Enhance Government's awareness of emerging health issues from the public's viewpoint.

- Establish committees to examine specific health issues, as required.

It is expected that the Health Council's role in establishing Health Goals will be a two-stage, evolutionary process. Initial Goals will be of a general nature, with more specific Goals and quantifiable objectives being developed as better health information becomes available.

Membership

The Health Council will not exceed 12 voting members, including the Chairperson. Members will be appointed by Order-in-Council. Membership will be composed of qualified individuals selected on the basis of competence and demonstrated leadership, and will reflect the pluralistic nature of Nova Scotian society. No organization or group shall have a presumed right to have representation on the Council. Members should not serve as representatives of specific organizations or interest groups.

Members will be selected through the provincial public appointment process, after a call for nominations from the public. All appointments will be on a volunteer basis, with members reimbursed only for expenses. Members will be appointed for staggered three-year terms (four members' appointments will expire each year), with the option of one reappointment.

The Executive Director of the Health Council, the Deputy Minister of Health, and the Assistant Deputy Minister of the Policy and Planning Division, will serve as ex officio, non-voting members.

Administration

To carry out its mandate effectively and independently, the Provincial Health Council will be financed as a separate agency, and will be allocated its own budget.

The Provincial Health Council Secretariat will consist of an Executive Director, an Administrative Assistant, two Policy Analysts, and one Secretary. In consultation with the Department of Health, staff secondments may be considered for ad hoc assignments. The Health Council will have the ability to contract out consulting assignments as needed.

Relationship to the Department of Health and other Departments

The Provincial Health Council will operate independently from the Department of Health, determining its own agenda and its operational activities. At the same time, it must closely interact with the Department of Health, through the sharing of information and resources. To facilitate communication and coordinate planning initiatives, the Executive Director of the Health Council may attend Senior Staff Meetings of the Department of Health. Likewise, the Deputy Minister of the Department of Health, and the Assistant Deputy Minister of the Policy and Planning Division, will be ex officio members of the Health Council. The Health Council will also maintain liaison and communication with other relevant departments, such as Community Services, Education and Environment.

Standing Committees

It is recommended that the Provincial Health Council establish two Standing Committees to advise on issues that require immediate attention and more focused or technical analysis:

- Standing Committee on Health Goals; and
- Standing Committee on Health Technology.

Members of the Standing Committees will be drawn from the Health Council, with chairpersons appointed from Council membership. Appropriate external expertise will be added as required. The Standing Committees will report their findings and recommendations to the Provincial Health Council.

Standing Committee on Health Goals

The health care system should operate within a framework of provincial Health Goals. These Goals must be broadly defined in terms of improved health status. Goals allow the development of specific objectives which, in turn, serve as a basis for:

- development of new health care priorities and programmes; and
- evaluation of existing programmes.

The development of Health Goals is a fundamental concern and priority of the Health Council. The Standing Committee on Health Goals will deal specifically with the development of Goals and appropriate measures to promote their attainment.

The Standing Committee will be responsible for a thorough and rational process of developing Goals, and will recommend Goals and objectives to the Health Council.

Terms of Reference

The Standing Committee on Health Goals will:

- Develop objectives for the improvement and maintenance of Nova Scotians' health status.
- Recommend strategies for realizing these objectives.
- Promote programmes to improve public awareness of factors that influence health (e.g., lifestyle, diet, environmental concerns).
- Monitor and evaluate health outcomes.

Standing Committee on Health Technology

The Nova Scotia Royal Commission on Health Care recommended a Standing Committee on Technology Assessment.

Technology assessment involves both clinical evaluation of the efficacy/effectiveness of technology, and economic evaluation of its cost effectiveness. Cost effectiveness, in turn, may be measured in terms of the cost of health care outcomes (e.g. cost per quality adjusted life year) or in terms of the cost of a specific technology relative to alternatives.

Due to the often complex nature of technology assessment, and the expense, there is a good case for a single national body for technology assessment, with participation by federal and provincial governments.

The Advisory Committee on Institutional and Medical Services has established a Coordinating Office for Health Technology Assessment. The Coordinating Office has been in existence approximately one and one-half years. It appears that it may function primarily as a clearing house, which will maintain information on the results of technology assessment, and on research currently under way. Quebec has an Institute for Health Technology Assessment. Organizations are currently being established in Ontario and British Columbia as well. These developments would seem to preclude a joint federal-provincial effort to undertake technology assessment.

Although Nova Scotia has a considerable body of expertise, budget constraints argue against the establishment of an ongoing technology assessment body. There is a need to keep abreast of current information in the field of technology assessment. A process of information gathering for distribution to appropriate government departments and health organizations could be undertaken within the Policy and Planning Division of the Department of Health.

Health care technology includes a broad range of procedures for both diagnosis and treatment. A Standing Committee on Technology could encourage scientific investigation and expert discussion about the appropriate use of low cost (per unit) but high volume procedures that have proliferated in institutions and in medical practice.

There is also a need to promote the rational use and diffusion of technology. The Standing Committee on Health Technology can fill this role by creating public discussion about the effectiveness and efficiency of specific technologies. Ideally, such informed discussion about the appropriateness of new technologies could replace a sometimes adversarial process of lobbying government and the public by interest groups or health care providers.

A Standing Committee on Health Technology would include Council members. Scientists, academics and health care professionals would be invited to participate in Committee discussions of specific issues where they have recognized expertise or a record of public interest and involvement.

Terms of Reference

The Standing Committee on Technology will:

- Coordinate provincial efforts to achieve a rational use of health care technology based on effectiveness in terms of health outcomes.
- Promote efficiency studies as a precondition to implementation of new technology.
- Create a forum for informed public discussion and dissemination of information on technology use.
- Provide expert opinion on questions of technology use and acquisition referred to Health Council by government.
- Attempt to build professional consensus on the standards that should govern the use of high volume technologies (such as diagnostic tests).
- Encourage technology evaluation by the scientific community in Nova Scotia.

BACKGROUND TO REGIONALIZATION STRATEGY

Existing Examples of Regionalization in Nova Scotia

There are several examples of regionalization of certain aspects of health care in the province. Several of these regionalization efforts pertain to hospital services.

The Cape Breton Regional Services Committee provides a mechanism for joint planning among the hospitals of Cape Breton, with a particular focus on Industrial Cape Breton. Among the Committee's stated objectives are: the avoidance of unnecessary duplication of services; the efficient use of available resources; and exploration of rationalization, coordination and sharing of services. The Committee has had success in rationalizing some services — for example: certain medical specialties.

The Metropolitan Hospital Advisory Committee (MHAC) is a vehicle for joint planning among the hospitals of the Halifax-Dartmouth metro area. In describing the organization's purpose and activities, MHAC's terms of reference refer to inter-hospital collaboration, coordination of institutional planning and initiatives for operational efficiencies.

The Lunenburg-Queens Planning Council was established in May 1990. Three hospitals are represented on the Council: Fishermen's Memorial, South Shore Regional and Queens General. The Council's goal is to foster cooperation among the three hospitals, to rationalize services and ensure quality care.

The Nova Scotia Commission on Drug Dependency has regional offices and advisory boards in each of its five regions.

The Department of Health and Fitness Division of Community Health is regionalized in that it has field staff based in seven regions around the province. Each region is referred to as a Health Unit and is headed by a Director.

The Department's Division of Psychiatric Mental Health Services is also pursuing a regionalized approach, including regional planning mechanisms — for example, the Metro Mental Health Planning Board.

Developments in Other Provinces

Governments in several other provinces have already moved towards regionalization of health services and/or are have received recommendations for decentralization. Models used or proposed in other provinces are not necessarily transferrable to Nova Scotia, due to differences in population, geography and culture; nevertheless, Nova Scotia can learn from other provinces' experience.

In *Alberta*, the December 1989 final report of the Premier's Commission on Future Health Care for Albertans recommended the creation of nine health regions and major decentralization of authority — in particular, the power to allocate funds — to elected regional health authorities.[1]

The 1990 report of the *Saskatchewan* Commission on Directions in Health Care also recommended radical decentralization of authority, to 15 elected regional health councils. The councils would have "...authority and responsibility for all aspects of health care, including programme planning, evaluation, budget allocation and management..."[2]

The Royal Commission on Health Care and Costs in *British Columbia* has as one of its terms of reference a consideration of regional health authorities.

In *Ontario*, regionalization of health services began in 1973, when the first District Health Council was set up. There are now 28 such councils, covering more than 90% of the province's population. The councils' role is advisory, and council members are appointed by the Minister of Health.

The overall mandate of the Ontario councils is "to identify the health care needs in their area and examine ways of meeting them." Specific functions have included: rationalization of services provided by health care institutions; review of proposed hospital equipment acquisitions; and developing regional proposals in specific programme areas such as long-term care, mental health and drug dependency. The Premier's Council on Health Strategy in Ontario is currently examining decentralization of services.

1. **Rainbow Report: Our Vision for Health** (Edmonton, Alberta, December, 1989).
2. **Future Directions for Health Care in Saskatchewan**, (Saskatchewan, 1990).

Quebec has also had regional health councils for many years. The councils have acquired significant authority and deal with health and social service issues. (In Quebec, health and social services are under the responsibility of a single Ministry.) The Rochon Commission Report, presented in 1988, recommended further extensive devolution of authority to the regions.[3]

Regional Health Agencies: Goals, Tasks, Membership, Operations

(a) Functions

Drawing on information and analysis supplied by the Department of Health, each Regional Health Agency will have the following functions: evaluation of the health status of the region's population; identification of health needs (in the context of province-wide Health Goals set by the Provincial Health Council); identification of cost-effective services to meet identified needs; and monitoring of service delivery.

Effective region-specific planning requires that data and analysis on health status and health services be available on a regional basis. Significant upgrading of the Department of Health's information systems and research capabilities will be needed in order to generate the necessary data and analysis.

(b) Tasks

The following are some of the specific tasks Regional Health Agencies may undertake, with the Department of Health supplying needed information and analysis: promote rationalization of health services in the region (e.g. prevent or eliminate unnecessary duplication of services); promote integration of services (e.g. integrated long-term care, which could involve home care, hospital services and Homes for Special Care); develop, and update periodically, a costed regional **Health Services Plan**, based on indicative multi-year global budget figures from the Department of Health; develop, and update periodically, a regional physician manpower plan (consistent with the overall provincial plan, in whose development Regional Health Agencies will participate); monitor (annually) health status and utilization of health care services, in particular physicians' services and Pharmacare.

3. La Commission d'enquête sur les services de santé et les services sociaux, **Rapport**. (Québec: Les Publications du Québec, 1988).

(c) Membership and Operations of Regional Health Agency Boards

The membership of the Regional Health Agency boards will vary by region, so that the membership of a given region's board reflects all key aspects of health and health care in that particular region (including aspects that do not come under the jurisdiction of the Department of Health). The interests of all key service providers in the region will be represented. The board will have an equitable balance of health care users (including community groups) and providers. The board's members will come from diverse backgrounds.

The total number of voting members on each Regional Health Agency board (which may vary from region to region) will be kept small enough to ensure that the board is functional. **A total of 12-18 members is suggested**. In general, the boards will seek to arrive at decisions by consensus rather than formal voting.

Members of Regional Health Agency boards, and the chairpersons, will be appointed by the Minister of Health, following a process of consultation with interested parties and a public call for nominations. In the future, when a vacancy occurs on the board of a Regional Health Agency, the board itself should also be consulted about the new appointment.

Persons who are already members of existing boards (e.g. hospital board) will be eligible for appointment to the boards of Regional Health Agencies.

Appropriate staff from the Department of Health will attend Regional Health Agency board meetings as non-voting resource persons.

The choice of chairpersons will be particularly important. Appointees should be persons of stature in their region and have the respect and trust of all interested parties.

Members of Regional Health Agency boards will be appointed for staggered three-year terms, so that one-third of the positions come up for appointment every year. Members will be eligible to serve a maximum of two consecutive terms.

The boards of Regional Health Agencies will establish sub-committees as they see fit. Sub-committees might be established, for example to deal with specific health issues (e.g. drug dependency) or to promote rationalization of services by bringing together provider representatives (e.g. Cape Breton Regional Services Committee). Appropriate persons who are not members of the agency board will be asked to serve on sub-committees.

Board members and persons serving on sub-committees will not receive honoraria for attending meetings, but will be reimbursed for all expenses related to their work for the Regional Health Agency. The operating principle will be that financial status should not be a barrier to participation.

(d) Administration of Regional Health Agencies

Each Regional Health Agency will select and employ its own staff. Each agency will have a small staff of 2-3 persons: a Regional Coordinator plus one or two support staff. Regional Health Agencies will be able to call on Department of Health staff to provide the information and studies the agencies will need to fulfil their mandate. Agencies could also be given small budgets to hire consultants.

Wherever possible, Regional Health Agencies will have their offices in an existing facility — for example, Regional Health Unit offices, a hospital or the offices of a non-governmental health organization.

Coordination of Regionalization with the Department of Health and the Provincial Health Council

(i) Regionalization will mean that the Department of Health consults Regional Health Agencies on all issues — whether of a policy, planning or operational nature — that concern, or could have an impact on, their region. Structures to facilitate this consultation are described in Chapter I.

(ii) If Regional Health Agencies and the Department of Health are to be able to analyze health needs on a regional basis, better information systems and additional research capabilities (including programme evaluation) will be needed at the Department of Health. For example, Regional Health Agencies will need information presented in a manner that enables them to identify trends and determine changing requirements for services and programmes. Timely data collection and analysis will require automated data in an integrated provincial network, and adequate numbers of staff with appropriate skills.

The information systems currently used by the Department of Health and Fitness are running on several computers, with unrelated methods of access. Improved health planning will require bringing together key data sets and implementing a unique patient identifier for all patient data. This improved database would allow for regional comparisons of demographics, health status (morbidity, mortality, etc.) and service utilization, as well as financial, health manpower and workload data.

This call for improved data collection and analysis is consistent with the Department's long-range systems plan — in particular, the plan's emphasis on improving access to existing automated data, creating an integrated health planning database, introducing a unique identifier for all patient records and automating data communications from providers of insured services.

Developing improved information systems, and "packaging" relevant information for Regional Health Agencies, will require retraining of some Department staff as well as hiring of new staff with the required skills.

(iii) The Regional Health Agencies will have an informal communication relationship with the Provincial Health Council. The Regional Health Agencies and the Council will share information and keep each other informed of their activities.

THE HEALTH SERVICES AND INSURANCE COMMISSION AND MARITIME MEDICAL CARE INC.

The Health Services and Insurance Commission (HSIC)

The HSIC was established in 1973 by the Health Services and Insurance Act. The Commission is responsible directly to the Minister of Health. The HSIC oversees the Medical Services Insurance plan (MSI), which insures the following health care services: physicians' services; children's dental services; vision analyses by optometrists; dental surgery; prosthetic services; special dental plans; Pharmacare (prescription drugs for seniors and disabled persons receiving Family Benefits); and special drug programmes.

The Health Services and Insurance Commission has responsibility for:

- negotiating tariffs with provider groups;
- establishing the tariff or tariffs of fees or other system of payment for insured services and authorizing payment;
- interpreting tariffs and determining their application to the assessment of claims;
- conducting surveys and research;
- recommending to the Minister changes in insured programmes; and
- providing policy direction to Maritime Medical Care Inc. (MMC).

The Nova Scotia Royal Commission on Health Care emphasized that the current arrangement — whereby HSIC functions outside the Department of Health — leads to fragmentation of the health care portfolio. The merger of HSIC with the Department of Health was strongly recommended in the Royal Commission's Report. Government accepts the Royal Commission's recommendation.

The Health Services and Insurance Commission will be integrated with the Department of Health, becoming the Insured Professional Services Division.

Under the reorganized Department of Health, responsibility for several functions currently being carried out by the Health Services and Insurance Commission and its committees will be allocated to committees appointed by the Minister of Health. These functions are: the negotiation and interpretation

of tariffs for providers; the due inquiry process; and the consideration of beneficiary and provider appeals regarding the eligibility of services for inclusion under MSI.

The following committees will be established by the Minister of Health: Negotiating Committee; Due Inquiry Committee; and Insured Services Appeal Board.

(a) Negotiating Committee

Negotiation of tariffs for all providers will be handled by a Negotiating Committee of senior government representatives, in order that agreements with providers be consistent with the broad financial policies of government and with the health human resource strategy. Senior officials from the Departments of Health, Finance and Management Board will be on this committee.

(b) Due Inquiry Committee

This committee will be appointed by the Minister of Health, and will be independent from the Department. It will ensure due process to providers whose billing practices are under review. Its membership will consist of both providers and consumers. Provider representatives will be chosen after consultation with professional associations. The Committee will include representation from the Department of Health (Insured Professional Services Division).

(c) Insured Services Appeal Board

An Insured Services Appeal Board will be established in order to deal fairly and independently with insured services appeals by both providers and beneficiaries. The Board will provide final decisions on eligibility of services for inclusion under the MSI Plan. Appointed by and reporting to the Minister of Health but independent from the Department, its membership will consist of both providers and consumers. Provider representatives will be chosen after consultation with professional associations. Representation from the Department of Health (Insured Professional Services Division) will be included in the committee's membership.

Statutory amendments to the Health Services and Insurance Act will be enacted, to officially dissolve the HSIC.

Maritime Medical Care Inc. (MMC)

(a) Background

Maritime Medical Care Inc. was established in 1948, as a non-profit organization, to sell prepaid health services programmes. In 1967, as part of the Province of Nova Scotia's planning to introduce publicly-funded medical care insurance, MMC entered into an Agreement with the Minister of Health to help design, and then administer, what became known as the Medical Services Insurance plan (MSI). Nova Scotia is the only province in Canada that has its insured-health-services plan administered by a private company.

MMC administers the MSI plan on a no-profit, no-loss basis; it is reimbursed by HSIC for all "reasonable costs." This arrangement has been criticized as providing insufficient control of MMC's costs. MMC's costs for administering MSI total more than $8 million per year.

The most recent version of the Agreement between the Minister of Health and MMC (dated July 19, 1984) sets out six broad functions that MMC is to perform:

- determine eligibility of receivers and providers of services;
- receive and assess claims according to policies prescribed by HSIC;
- make payments of approved claims with such frequency as HSIC directs;
- hear appeals arising from decisions of MMC's own officers or committees in the administration of the MSI Plan;
- develop systems and procedures to monitor utilization and unnecessary use of insured health services; and
- compile and analyze statistics from Plan data and prepare and submit reports as required by the Minister or HSIC.

The functions administered by MMC can be described in terms of the following continuum of activities:

(i) *Registration* of eligible beneficiaries and providers.

(ii) *Claims processing:* claims reception and data input; determination of eligibility; assessment; and payment of approved claims.

(iii) *Verification audit:* Each week, MMC sends out verification letters to one percent of the patients for whom claims have been processed.

(iv) *Research:* Utilization review; practice profile review; statistics gathering and analysis; programme evaluation; policy analysis and recommendations.

(b) Issues and Strategy

As the Royal Commission on Health Care pointed out its Report, MMC has over the years conducted research and policy analysis related to current and potential insured programmes. This includes policy-related auditing, such as reviews of providers' practice profiles and reviews of patterns of patients' utilization of services. Some of this work has been undertaken at the request of the Minister of Health or HSIC. A good portion, however, has been initiated by MMC itself; this reflects MMC's broad view of what is entailed in programme administration under its agreement with the Minister of Health. In sum, MMC has frequently been a policy advisor to government, and not simply an administrator of the MSI plan.

Research and policy analysis related to insured health services, which account for almost 30% of the total health budget, should not be conducted in isolation; rather, these should be integrated with other Department of Health research and analysis. These functions must, therefore, be performed within the Department of Health.

Research and policy analysis depend on the timely availability of information; however, as the Royal Commission emphasized, the MSI information systems need significant upgrading if they are to provide the needed datya. For this reason, and because the Department intends to explore the benefits of a unique patient identifier for all health services, it is desirable that the Department have a major role in developing the information systems related to insured health services.

The contract with MMC will be amended so that Department of Health is responsible for research and policy analysis (including policy-related audit) and assumes a major role in systems development.

DEPARTMENT OF HEALTH

Policy and Planning Division:

The functions of this division will be as follows:

(a) Planning

- Strategic planning coordination (long term, macro level).
- Health human resource planning.
- Coordination of programme planning (micro-level).
- Interdepartmental and intergovernmental policy considerations.
- Legislative change analysis (in consultation with Legal Counsel).
- Regional level planning and coordination.

(b) Evaluation

- Programme evaluation (cost effectiveness and health outcomes).
- Impact analysis of new programmes.
- Coordination and dissemination of technology information.

(c) Research and Statistics

- Statistical services.
- Research in operational areas (e.g. utilization of health services).
- Coordination of Department of Health research with other government research departments (e.g. provincial, interprovincial and federal).
- Liaison with academic researchers.
- Library services.
- Epidemiological research.

Modern information processing capabilities and access to health programme data bases will be essential if the Policy and Planning Division is to fulfil the functions outlined here. Close links between this division and the information systems unit of Corporate Services Division will be essential.

Corporate Services Division

The functions of this division will be as follows:

(a) Information Systems

- Systems development re: MSI
- Vital Statistics services.
- Health records consulting and management.

- Health statistics (computer produced).
- Departmental computer systems.
- CODD systems support.
- Hospital systems planning and consulting.
- Voice and data communications.
- Database administration.
- Support to Regional Health Agencies and Provincial Health Council.

(b) Finance

- Financial planning and analysis.
- Capital finance.
- Budgets.
- Auditing (financial and comprehensive).
- Accounting.
- Third party liability.
- Out-of-Province claims.
- Insured Professional Services (MSI) accounting.
- Coordination of regional financial planning.
- MIS coordination.
- Office services.
- Central supply.

(c) Personnel

- Departmental Personnel Services.
- Human Resource Development (career development, continuing education, training, rotations, secondments, etc.).

Health Care Facilities Division

The responsibilities of the division's three units will be as follows:

(a) Regional Operations (Acute care, Rehabilitative care, Continuing care)

- Monitoring general facility operations.
- Monitoring standards.
- Review and evaluation of staffing.
- Budget review for facilities.
- Expenditures.
- Facilities staff training and development.

(b) Construction and Maintenance

- Consulting services for facility renovation or construction.

(c) Consulting Services

- Consulting services in key programme areas, offered either via in-house consultants (e.g. Nursing, Medical, Dietetics, Home Care, Continuing Care, Purchasing, Pharmacy, Laboratory, Radiology) or via external consultants.

Mental Health Services Division

This division is responsible for development coordination and oversight of comprehensive mental health services on a regional basis. Major changes proposed for this division include a change in name from Psychiatric Mental Health Services, better integration with other departmental programme areas, and an emphasis on community mental health.

The following chart summarizes the hospital based programmes of the division.

HOSPITAL BASED MENTAL HEALTH SERVICES

Facility	In-patient Services	Partial Hospitalization	Out-patient Services	Satellite Clinics
Aberdeen Regional Hospital	Being Planned	Being Planned	YES	YES
Atlantic Child Guidance Centre	ON	NO	YES	YES
Camp Hill Medical Centre	YES	YES	YES	YES
Cape Breton Regional Hospital	YES	YES	YES	YES
Colchester Regional Hospital	Being Planned	YES	YES	NO
Hants Community Hospital	NO	NO	YES	NO
Izaak Walton Killam Hospital	YES	NO	YES	NO
Highland View Regional Hospital	NO	YES	YES	YES
Nova Scotia Hospital	YES	YES	YES	YES
St. Martha's Regional Hospital	YES	Being Planned	YES	YES
South Shore Regional Hospital	YES	Being Planned	YES	YES
Valley Health Services Association	YES	YES	YES	YES
Victoria General Hospital	YES	NO	Only Specialized Services	NO
Yarmouth Regional Hospital	YES	YES	YES	YES

The division will be made up of three units: adult psychiatric services; community mental health; and child & adolescent services. The units' responsibilities would be as follows:

(a) Adult Psychiatric Services

- Hospital-based inpatient and day psychiatric services, including budgeting, standards.
- Mental Health Consulting Services, including Health, Social Services, Psychiatric Nursing, and Psychology.

(b) Community Mental Health

- Mental health education, prevention, community mental health programmes, counselling, and outpatient psychiatry.
- Links with the Community Health and Health Promotion Division, and the Department of Community Services.

(c) Child and Adolescent Services

- Coordination of mental health services and development of facilities and programmes for children and youth, including both inpatient and community services.
- Links with the Department of Community Services.

Drug Dependency Services Division (DDSD)

The functions of DDSD will be adapted from the current Drug Dependency Act, Section 5, and will include:

(a) Programmes to:

- conduct, direct and promote the treatment and rehabilitation of drug dependent individuals and their families;
- provide comprehensive drug dependency prevention information and education to the community-at-large and to community care-givers;
- provide consultation and/or training and/or skills development for personnel and community care-givers about drug dependency; and
- undertake specialized pharmacological information and street drug analysis.

(b) Policy and research activities to:

- implement medium and long-range strategic planning as outlined in the Strategic Plan (November 1988);
- set standards for facilities, programmes and personnel in the area of drug dependency;

- review legislative policy relating to drug dependency and make recommendations for improvements;
- identify research needs, implement pilot projects, and undertake evaluation; and
- maintain a province-wide statistical information system concerning drug dependency.

*(c) **Coordination of:***

- activities and services with other Divisions and Departments in order to avoid duplication;
- interdepartmental, inter-provincial and federal-provincial activities to maintain and maximize cost-sharing agreements;
- special province-wide projects (eg. Drug Awareness Week); and
- the dissemination of information regarding prevention, recognition and treatment of drug dependency.

TASK FORCE ON NURSING

Terms of Reference

The Task Force will develop strategies and recommend action plans to address the following areas:

(a) Human Resource Planning

(i) Develop a comprehensive human resource plan for nurses. This would include planning at the community, regional and provincial levels.

(ii) Explore the changing role of the nurse and determine how this role can be assimilated into a comprehensive human resource plan.

(iii) Explore the role of the certified nursing assistant and other nursing support personnel and determine how these roles can be assimilated into a comprehensive human resource plan.

(b) Education

(i) Assess nursing education needs and/or requirements in the context of a changing health care system.

(ii) Develop an implementation strategy to meet the identified educational requirements of nurses in collaboration with government, universities and diploma schools of nursing.

(iii) Identify innovative methods of financing continuing education and post-graduate education.

(c) Nursing Professional/Worklife Issues

(i) Identify worklife issues related to the nursing profession.

(ii) Establish priorities and develop implementation strategies to improve the worklife of nurses and enhance professional development.

(iii) Explore mechanisms to monitor the long term development and implementation of nursing initiatives, for example those recommended by the Task Force on Nursing.

(d) Innovative Nursing Projects

(i) Explore, identify and develop strategies to implement innovative nursing projects. This may include the administrative framework required to implement the role of the nurse in primary health care and participatory management models, specialty nursing projects, flexible staffing options, and other projects the Task Force may identify.

The projects proposed will address effectiveness, efficiency and cost-benefit considerations. In addition, the projects will incorporate the concept that nurses are members of a multi-disciplinary, intersectoral team.

Membership

The Task Force on Nursing will be comprised of 16 members, including the Chairperson. The Chairperson will be appointed by the Minister of Health. The other members of the Task Force will be appointed by the Minister of Health after nominations are received from the groups listed below (each group will be allowed to submit up to three nominees per position):

1. Registered Nurses Association of Nova Scotia
   1 representative

2. Staff Nurses
   1 from NSGEU
   1 from NSNU
   1 other

3. Directors of Nursing
   1 from Senior Nurse Administrators of Nova Scotia

4. Nursing Education
   1 from university Schools of Nursing
   1 from diploma Schools of Nursing

5. Certified Nursing Assistants
   1 representative

6. Nova Scotia Medical Society
   1 representative

7. Nova Scotia Association of Health Organizations
   1 representative

8. Public Health Association of Nova Scotia
   1 representative

9. Department of Health
   1 representative from Policy and Planning Division (Human Resource Planning)
   1 representative from Facilities Division (a nursing consultant)

10. Department of Community Services
   1 representative

11. Associated Homes for Special Care
   1 representative

Administrative Support for the Task Force

A secretariat, including clerical support, will be provided by the Department of Health (DOH). The RNANS will provide a liaison/research person to coordinate the activities of the Task Force relevant to the RNANS.

The staff support will be as follows:

1 FTE Coordinator, (DOH)

1 FTE clerical support person (DOH)

1 FTE liaison/research coordinator (RNANS)

The Coordinator, a nurse seconded from the Department of Health, will provide the overall administrative and support functions necessary to facilitate the work of the Task Force. The coordinator will attend meetings of the Task Force and its Sub-Committees as required.

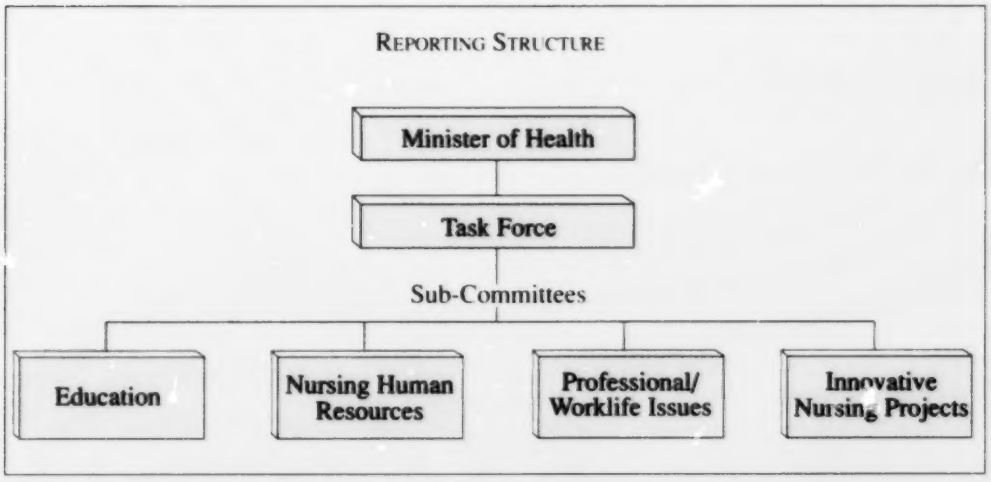
In carrying out its duties, the Task Force may request additional staff support from the Department of Health. External consultants will be contracted if required.

Sub-Committee Structure

Given the mandate of the Task Force, it is recommended that Sub-Committees be established to develop implementation strategies in the following areas:

- Human Resource Planning
- Education
- Professional/Worklife Issues
- Innovative Nursing Projects

Chairpersons of Sub-Committees will be members of the Task Force. Sub-Committees may have some members, from the health care community, that are not members of the Task Force. Membership on the Sub-Committees will be determined by the Task Force. Staff nurses will be represented on each of the Sub-Committees and the Task Force. Terms of reference for the Sub-Committees will be developed by the Task Force.



Reporting Schedule

The Nursing Task Force will report to the Minister of Health within 18 to 24 months of its formation. Interim reports will be made to the Minister at regular intervals.

The Sub-Committees will report at varying intervals, depending on the work-load of their specific group. Suggested reporting schedules are as follows:

Nursing Human Resources	12 months
Education Sub-Committee	9 months
Worklife Issues	6 months
Innovative Nursing Projects	6 months

The Sub-Committees will report 6 to 12 months before the Task Force will prepare its final report. This will permit the members of the Task Force time to assimilate and integrate the information and prepare a final report to present to the Minister of Health.

MINISTERIAL COMMITTEE ON PHYSICIAN POLICY

Terms of Reference

The primary goal of the Ministerial Committee will be to make recommendations to Government to achieve an appropriate mix and distribution of physician human resources that enables a cost-effective use of resources in providing optimal quality health services.

The principal thrust of the Ministerial Committee will be to develop strategies to manage health care expenditures associated with utilization of physician services, through the establishment of physician manpower levels appropriate to Nova Scotia's needs and through the examination of modified/alternate methods of remuneration.

The Ministerial Committee will develop resource management strategies and time-specific action plans with respect to the following primary objectives:

1. To achieve an orderly growth and equitable distribution of physician human resources:

- develop strategies for achieving identified physician manpower targets (i.e. number and mix of medical personnel) in keeping with the principles of resource-based, regional planning;
- develop a human resource plan to achieve these target levels of physician manpower supply;
- identify appropriate incentive/disincentive measures to improve the geographic distribution of physicians;
- assess outcomes of service delivery and variations in practice profiles; and
- in recognition of physicians as a national resource, develop a provincial plan that is consistent with, and contributes to, current national and regional physician human resource planning initiatives regarding:
  - (i) medical school enrolments
  - (ii) lengthening of training requirements
  - (iii) immigration
  - (iv) visa trainees
  - (v) sub-specialization
  - (vi) licensure requirements.

2. **To achieve a managed growth in physician expenditures:**

- develop proposals - with physician and public cooperation - to achieve a managed growth strategy with respect to expenditures on physician services;

- examine and recommend alternative/mixed reimbursement mechanisms for institutional, community and university based physicians that promotes efficient and effective health care delivery; and

- examine measures to increase accountability of Dalhousie University Faculty of Medicine in view of regional physician human resource requirements.

Membership

The Committee will report to the Minister of Health.

Members of the Ministerial Committee are to be appointed by the Minister after nominations are received from the professional bodies and organizations listed below. The Chairperson of the Ministerial Committee, not necessarily a physician nor representing a professional body, will be appointed by the Minister of Health.

The Ministerial Committee will be comprised of 17 members, including the Chairman, with one representative — unless otherwise indicated — from the following groups:

1. Nova Scotia Provincial Medical Board;
2. Dalhousie University Faculty of Medicine:
   Office of the Dean of Medicine
   Department of Community Health & Epidemiology;
3. Nova Scotia Medical Society:
   2 representatives
4. Professional Association of Residents & Interns - Maritime Provinces;
5. Nova Scotia Association of Health Organizations;
6. Nova Scotia Public Health Association;

7. Registered Nurses Association of Nova Scotia;
8. Nova Scotia Health Action Coalition;
9. Federation of Community Health Clinics of Nova Scotia;
10. Department of Finance/Management Board
11. Nova Scotia Department of Health:
    Facilities Division (2 representatives, one of which will be a Medical Consultant)
    Insured Professional Services Division
    Policy and Planning Division

Sub-Committee Structure

In view of the broad mandate of the Ministerial Committee, it is recommended that two Sub-Committees be established to develop policy options and detailed implementation strategies in the two principal areas for consideration by the Committee:

1. Physician Human Resources Planning (includes integration & coordination of provincial, regional and national planning initiatives);
2. Managed Growth Strategy with regards to expenditures on Physician Services (includes alternative modes of remuneration)

Chairpersons of the Sub-Committees will be members of the Ministerial Committee. Membership of the Sub-Committees will be selected by the main Committee. Ad hoc representation may be considered on an as needed basis.

Administrative Support

The Department of Health will act as Secretariat to the Steering Committee and its Sub-Committees and provide clerical support services as required.

The Secretariat shall consist of a part-time Coordinator, seconded from the Department of Health and reporting to the Chairman, to provide the overall administrative and support functions necessary to facilitate the work of the Ministerial Committee. Part-time secretarial support will also be seconded.

External consultants, approved by the Minister of Health, may be contracted as required to fulfil the mandate of the Ministerial Committee.

Time Frame

Sub-Committees will be expected to report to the main Committee within 9 months.

Progress Reports will be provided to the Minister on a regular basis.

WORKING GROUP ON PRIMARY HEALTH CARE DELIVERY

Objectives

The objective of the Working Group on Primary Health Care Delivery is to oversee the design, implementation and evaluation of models of health care delivery that:

- promote a change of philosophy to Primary Health Care, with emphasis on integrated prevention, promotion, treatment and rehabilitation services delivered to the individual in his or her community;
- foster local and regional integration of health related services, including enhancement of community cooperation and development;
- match health resources to local needs;
- achieve inter and intra-departmental coordination; and
- are cost effective and outcome oriented.

To achieve the above objectives, the Working Group will investigate models of delivery as potential pilot projects, with a long-range goal of evaluation and possible widespread implementation. A number of pilot projects could be explored for both rural and urban areas, ranging from those utilizing different providers (e.g., nurse practitioners, health educators, etc.), different settings of care (e.g., redefined community hospitals, day hospitals, freestanding clinics, etc.), different methods of remuneration (i.e., salary or capitation) and a greater emphasis on health promotion, illness prevention, and community development.

This process must take place within the broader planning context of the health care system, and must be linked to the Health Goals and strategic objectives for the province. Within the present fiscal situation of the province, models chosen must reasonably be expected to provide services in a cost effective manner, providing improved health at similar or lower costs than comparable services are provided. Finally, models must allow redistribution or reallocation of current funding, and must not be seen as long term add-on costs.

Terms of Reference

The Working Group on Primary Health Care Delivery will:

- Examine the current roles of health care delivery agencies, including government departments and private delivery agencies, and address organizational barriers to delivery of integrated care.

- Establish broad criteria for proposals to the Working Group (e.g., requirements for participation of community groups and agencies delivering health related programmes, willingness to try alternative funding/organization arrangements, commitment to use of existing funding in innovative ways, clear understanding of existing community, regional and provincial resources and willingness to share/loan these resources, etc.)

- Review proposals from community and provider groups for possible Primary Health Care pilots.

- Examine models of health care delivery that would have as a basis the Primary Health Care approach.

- Select possible models for pilot projects.

- Establish parameters for models to be implemented, and guidelines for implementation, objectives, commitment of community, volunteers, professional involvement, and termination, if unsuccessful.

- Set up steering committees for each pilot project to coordinate and evaluate projects.

- Define outcome measures related to cost and to effectiveness that will be used to evaluate pilot projects.

- Design consistent evaluation methodology for pilot projects.

- Identify several communities in which there is potential for an integrated pilot project (i.e. a more coordinated approach, several agencies on local basis already cooperating, etc).

- Identify health care needs of communities within the context of regional and local resources, through methods such as existing data analysis (epidemiological data, Statistics Canada data), key informant interviews, community forums, and other social indicators.

- Refine pilot models to suit needs of community.
- Evaluate pilot projects and recommend further implementation if successful or termination if unsuccessful.

Membership

To ensure that the activities of the Working Group are fully integrated into the Department of Health's overall plans and programmes, the Working Group's coordinator will be a Department of Health employee.

The Working Group on Primary Health Care Delivery will be made up of representatives from:

1. The following divisions of the Department of Health:
   Health Care Facilities;
   Community Health and Health Promotion;
   Mental Health Services;
   Drug Dependency Services;
   Policy and Planning; and
   Insured Professional Services.

2. Department of Community Services.

Depending upon the models chosen, separate steering committees could be set up for each pilot project. Additional members for the steering committees will be drawn from various community groups and associations including:

Nova Scotia Association of Health Organizations;
Federation of Community Health Centres;
Associated Homes for Special Care;
Public Health Association of Nova Scotia;
Medical Society of Nova Scotia;
Registered Nurses' Association of Nova Scotia;
Union of Nova Scotia Municipalities; and
Other groups as required.

Reporting Structure

The Working Group on Primary Health Care Delivery will report to the Deputy Minister of Health through the Senior Staff Committee.

Individual steering committees could report to different divisions within Health or Community Services on an ad hoc basis on operational issues, depending upon the nature of the pilot project.

Time Frame

The proposed timeframe for the developmental stages of the project is six to eight months, to define guidelines for pilot projects, determine appropriate communities, assist in needs assessment, and define evaluation methodology.

It is anticipated that implementation and ongoing operation of pilot projects will continue for an 18 - 24 month period, with evaluation taking place after that time.

WORKING GROUP ON MENTAL HEALTH SERVICES

Mandate

The mandate of this working group will be to develop a Provincial Mental Health Services Plan by:

- examining the current status of mental health services in Nova Scotia;
- determining the mental health needs of the population, by region;
- identifying policies and programmes to meet the mental health needs;
- assessing the human resource needs;
- examining the structure for the delivery of mental health services, developing and testing a model;

The Working Group may then:

- redefine the role of the Mental Health Services Division in light of the Provincial Mental Health Services Plan; and
- make recommendations to the Minister concerning the establishment of a standing group/committee on mental health issues.

Membership

Members of the Working Group are to be appointed by the Minister after nominations are received from the professional bodies and organizations listed below. The Chairperson will be appointed by the Minister of Health.

The Working Group will be comprised of 16 members, including the Chairperson, with representation from the following groups:

1. Department of Health: Mental Health Services Division.

2. Canadian Mental Health Association.
3. Medical Society of Nova Scotia.
4. Nova Scotia Psychiatric Association.
5. Registered Nurses Association of Nova Scotia.
6. Nova Scotia Association of Psychologists.
7. Nova Scotia Department of Community Services.
8. Nova Scotia Office of the Attorney General.
9. Nova Scotia Office of the Solicitor General.
10. N.S. Advisory Council on the Status of Women.
11. Department of Advanced Education and Job Training.
12. Friends of Schizophrenics.
13. Association of Family and Children's Services.
14. A Municipal Department of Social Planning.
15. Nova Scotia Association of Occupational Therapists.
16. Nova Scotia Association of Social Workers.

The Working Group may choose to develop a central steering committee, and to co-opt members for sub-committees as it deems appropriate.

Time Frame

It is recommended the Working Group on Mental Health Services report within 12 months of its establishment.

Reporting Structure

The Working Group on Mental Health Services will report directly to the Minister of Health. It will provide interim reports to the Minister at regular intervals.

Administrative Support

- One part-time Administrative Coordinator to be provided by the Department of Health.

- One part-time clerical support person to be provided by the Department of Health.

AMBULANCE SERVICES ADVISORY COMMITTEE

Committee Membership

The following organizations are represented on the Ambulance Services Advisory Committee:

- Nova Scotia Ambulance Operators Association (3)
- Nova Scotia Registered Nurses Association
- Nova Scotia Medical Society
- Nova Scotia Society of Ambulance Personnel
- Nova Scotia Association of Health Organizations
- Victoria General Hospital
- Department of Health - Health Care Institutions Division
- HSIC

Staff support will be provided by the Insured Professional Services Division of the Department of Health.

ADVISORY COMMITTEE ON DRUG UTILIZATION

Strategies

Strategies will be designed to create the most effective methods to educate both the public and professional groups. To that end, the Committee will:

- Review information from the seniors' and Community Services Pharmacare programmes. Make prescribers and pharmacies aware of drug usage patterns that may represent potential over-utilization or hazardous utilization.

- Review research results and advise on ways to act on their findings (e.g. "Seniors and their Medicines").

- Review clinical experience with the use of drugs by selected groups of seniors.

- Identify lifestyle problems associated with drug use (e.g. falls among the elderly). Identify problems associated with drug use by institutionalized persons (especially those in nursing homes).

- Establish close ties with seniors' groups, which may play a leading role in educating seniors about drug issues. In its response to the Minister, the Senior Citizens Commission offered to promote a drug awareness campaign at its seminars and workshops throughout the province. Such contacts may offer the greatest potential for disseminating information to seniors, and for receiving feedback from them.

- Design education campaigns for prescribers and pharmacists, including continuing medical education programmes.

Methods

The Advisory Committee would review information provided by support staff and provide informed input in areas such as:

- Potential hazardous utilization.

- Non-hazardous utilization that may impair lifestyle.

- Prescribing standards, or approaches to the problems of defining standards.

- Ways to control utilization where patients are treated by more than one physician.

- Ways to communicate with the public.

- Ways to communicate with professionals.

Activities

Public and professional education will require a cooperative effort. Monitoring compliance with standards is a function of peer review or drug utilization review. A consensus reached by the Advisory Committee will facilitate efforts that may best be carried out by administrators of Pharmacare plans or professional review bodies.

Initially the Advisory Committee will focus on the seniors' and Community Services Pharmacare plans. The Committee will seek to understand problems of inappropriate utilization and prescribing within these plans and recommend approaches to deal with them.

At a later stage the Advisory Committee could advise on ways to identify needs of the currently-uninsured persons.

Membership

Membership on the Advisory Committee should include representatives from:

Nova Scotia Medical Society;

Nova Scotia Pharmaceutical Society;

Registered Nurses' Association of Nova Scotia;

Nova Scotia Association of Health Organizations;

Associated Homes for Special Care; and

Centre for Health Care of the Elderly, Camp Hill Hospital.

Representatives would be chosen from a list of up to three nominees from each organization.

Seniors' representatives would include representatives of the following organizations:

Senior Citizens Commission;

Canadian Pensioners Concerned Inc.; and

Federation of Senior Citizens & Pensioners.

Government representatives would be drawn from:

Department of Health (Insured Professional Services Division; Community Health & Health Promotion Division (health promotion unit); Drug Dependency Services Division; and Health Care Facilities Division (nursing consultant).

Senior Citizens Secretariat;

Department of Community Services;

Support staff would consist of:

Coordinator;

Pharmacist Consultant (from Insured Professional Services Division);•

Medical Consultant (Insured Professional Services Division);

Research Support (Policy & Planning Division); and

Secretarial Support (Insured Professional Services Division).

The Committee will report to the Minister of Health.

SUMMARY OF POLICY AND PROGRAMME INITIATIVES

Chapter I

Part 1: Provincial Health Council:

The Provincial Health Council will provide a forum for broad public participation in health planning and in the establishment of Health Goals for the province. The Health Council will be established, and begin its work, immediately.

Part 2: Interdepartmental Coordination:

A Senior Interdepartmental Committee on Health Policies and Programmes will be created. The standing members of the Committee will include Ministers and Deputy Ministers from the following departments: Health, Community Services, Education, Solicitor General, Environment, Housing and Labour. Representatives of other departments will be seconded as needed.

Part 3: Regionalization of Health Planning and Services:

Government will proceed as soon as possible with regionalization of health-related planning and services, by establishing Regional Health Agencies in all regions of the province.

Government will examine decentralization at a later date, based on evaluation of the experience with regionalization.

Six Regional Health Agencies will be established, based on the following regions (depicted on Figure 5).

All divisions of the Department of Health will use these regions for planning and operational purposes.

Part 4: Department of Health:

Reorganization of the Department of Health will be addressed as a first priority.

These reorganizational measures are outlined below.

The Department of Health will be comprised of five operational divisions — Health Care Facilities, Insured Professional Services, Community Health and Health Promotion, Mental Health Services, and Drug Dependency Services — and two support divisions, Policy and Planning and Corporate Services (see Organization Chart, Figure 7).

The Department's name will be changed to "Department of Health". The title "Division Administrator" will be changed to be more consistent with other Departments in Nova Scotia and elsewhere: the title "Assistant Deputy Minister" will be used for all divisional heads.

Regional Coordinating Groups will be established, one for each of the six proposed health regions. These groups will bring together appropriate staff for the region concerned so as to ensure coordination and integration of planning and service delivery.

The Department of Health will create and chair a Regional Health Agency Planning Committee, to be comprised of the chairpersons of the six Regional Health Agency boards and senior Department staff.

The Agreement with MMC will be amended so that the Department of Health will assume responsibility for research and policy analysis with respect to MSI programmes.

The Agreement with Maritime Medical Care Inc. (MMC) will be amended so that the Department of Health will assume a major role in systems development with respect to MSI programmes.

The Health Services and Insurance Commission (HSIC) will be integrated with the Department of Health, becoming the Insured Professional Services Division.

The following committees will be established by the Minister of Health: a Negotiating Committee, a Due Inquiry Committee, and an Insured Services Appeal Board.

To ensure that drug dependency services are fully integrated with other health services, the Commission on Drug Dependency will be integrated with the Department of Health, becoming the Drug Dependency Services Division.

The provincial advisory functions hitherto provided by the Commission on Drug Dependency will be maintained, by establishing a Minister's Advisory Committee on Substance Abuse.

Chapter II

Part 1: Nurses:

The Task Force on Nursing will be formed, and begin its work, as soon as possible.

Part 2: Physicians:

A Ministerial Committee on Physician Policy will be formed, and begin its work as soon as possible.

Part 3: Associate Health Professions:

A comprehensive health human resource management information system will be developed by the Department of Health, in consultation with the health professions.

The mandate of the Nova Scotia Advisory Commission on Health Human Resources will be expanded to include matters pertaining to all health professions in Nova Scotia.

Chapter III

Introduction

Spending on community health programmes, including health promotion, will be increased from 2.2% of the Department of Health budget to approximately 4% within five years. This will be achieved by internal reallocation within the Department's overall budget.

The rate of increase of total Provincial Government spending on health will be reduced.

Part 1: Primary Health Care Delivery:

The Government of Nova Scotia will promote the Primary Health Care approach in all regions of the province. The Department of Health will integrate Primary Health Care principles into its departmental Strategic Plan.

The Department of Health will set up a Working Group on Primary Health Care Delivery to help communities develop integrated approaches to primary health care. The Working Group will work in consultation with other departments and agencies involved in related service delivery.

Part 2: Community Health and Health Promotion:

A committee with joint participation by Community Health and Health Promotion Division central office and Regional Health Units will be established to maintain definition of their respective priorities, roles and objectives.

Part 3: Acute Care:

Rationalization of the hospital sector has been initiated by the Department of Health, and will be continued.

Part 4: Continuing Care:

The management of continuing care services will be strengthened.

To achieve these objectives, the following specific measures will be taken:

1. The Home Care Coordinating Agency will be renamed the Continuing Care Coordinating Agency and its mandate will be broadened to include all continuing care services (including the Coordinated Home Care Programme). The Continuing Care Coordinating Agency will provide policy direction and leadership. It will work in close consultation with Regional Health Agencies in meeting the mandate of coordinating continuing care services at the regional level.

2. The possibility of establishing a single entry point for all continuing care services in each area of the province will be examined. These entry points would operate according to provincial standards and guidelines to be established under the auspices of the Continuing Care Coordinating Agency.

3. Within the Community Health and Health Promotion Division of the Department of Health, separation of the CHCP nursing-care component from the community health nursing function (health promotion and disease prevention) will be instituted.

4. An evaluation of the Coordinated Home Care Programme (CHCP) will be completed. After this evaluation is complete, the desirability of expanding the CHCP to include additional services and/or target groups will be examined. In addition, the question of which division within the Department of Health should administer the CHCP will be reviewed. (Home Care is a treatment programme, and as such should eventually be administered by the Facilities Division, which has responsibility for treatment services.)

5. A review of Level III care will be undertaken, in particular to determine if providing Level III care in Nursing Homes would be more appropriate and/or less costly than providing it in hospitals.

Part 5: Mental Health Services:

The Nova Scotia Hospital will become an independent corporation, subject to the same rules and regulations as other hospitals in the province.

A Working Group on Mental Health Services will be established by the Minister of Health.

Part 7: Ambulances:

Government supports the establishment and priorities of the Ambulance Services Advisory Committee, in keeping with the recommendation of the Nova Scotia Royal Commission on Health Care, and will promote enhanced management of ambulance services in Nova Scotia.

Part 8: Pharmacare:

An Advisory Committee on Drug Utilization will be established.

Acute care - Care or treatment for illness of short duration or sudden onset, requiring concentrated medical and nursing attention.

Adult Residential Centre - Facility for persons who are mentally handicapped; in particular those who require longer term living environments, and which provide rehabilitation training and developmental programming.

Associate Health Professions - Persons with special training in fields related to medicine, such as physiotherapy, occupational therapy, audiology, and medical social work. Associate health professionals work with physicians and other health professionals.

Community-based health care - Health care provided to persons who reside in the community - i.e. persons who are not inpatients of a hospital. Community-based health care services include home care, outpatient services and day-hospital programmes.

Community health services - Services oriented to the maintenance or enhancement of health - e.g. health promotion and disease prevention.

Continuum of care - Health services can be considered to form a continuum, ranging from health promotion and disease prevention activities at one end to sophisticated, tertiary level acute care at the other.

Continuing care - Care that deals with chronic illness or disability. The main focus is on providing personal care and/or health care to maintain the patient's health status and quality of life.

Coordination of services - Ensuring that providers of various services are aware of each others' activities and seek to maximize the efficiency (service output/cost) and effectiveness (impact) of their separate services.

Decentralization (of health planning and services) - Delegation of responsibility and operating authority from a central body (e.g. Department of Health) to regional bodies.

Developmental Residence - Facility which provides intensive life skills and community orientation and training for severely mentally handicapped adults (approximately 8 per residence).

Epidemiology - The study of determinants of health and disease in human populations; includes the study of incidence, distribution, and control of disease in a given population. May be divided into: (i) classical epidemiology, which focuses on chronic and communicable diseases; and (ii) clinical epidemiology, which deals with personal or community health care and with evaluation of the effectiveness of treatments.

Group Home - Training facility for mentally handicapped persons providing assistance in the development of social skills, basic community living skills, and general adaptation to community life. A group home may serve either mentally retarded adults, post mentally ill or physically disabled adults.

Health care - Those services provided to individuals or communities through health organizations or professions. The aim of health care is to promote, maintain, restore, and monitor health. It is not limited to medical care provided by physicians, but includes many professions.

Health outcomes - The results, as measured by health status indicators, of health care.

Health promotion - The process of enabling people to increase control over and improve their health. It involves the population as a whole in the context of everyday life.

Health status - The state of health of persons in a community. Examples of health status indicators include mortality rates, disability days, potential years of life lost (PYLL) and life expectancy.

Home for the Aged - A non-profit facility operated by a Municipal Corporation or under the Societies Act for residents who are in need of care and supervision, and who are usually 65 years or older when admitted.

Homes for Special Care - An 'umbrella' term that includes the following types of facilities: nursing homes, homes for the aged, adult residential centres, regional rehabilitation centres, group homes and developmental residences.

Integration of services - The linking of services offered by two or more organizations/agencies. May involve the offering of joint/combined service.

Levels of Care (provided in various types of facilities):

(a) Level I Care - Residential Care or Personal Care. Residential, ambulant or limited personal care.

(b) Level II Care - Extended Health Care or Intermediate Care. Intensive personal care with nursing supervision or nursing home care.

(c) Level III Care - Chronic Care or Extended Care. Extended care in a chronic care unit or hospital.

(d) Level IV Care - Special care for a stable disability in a rehabilitation centre or hospital.

(e) Level V Care - Acute care of seriously or critically ill person in a hospital.

Life expectancy - A statistical projection of the number of years an individual is expected to live. Life expectancy can be calculated from birth or from some other age.

Medical Services Insurance plan (MSI) - Nova Scotia's publicly-financed health insurance plan. MSI insures the following services: physicians' services; children's dental services; dental surgery; special dental plans; vision analyses by optometrists; prosthetic services; Pharmacare (prescription drugs for seniors and for disabled persons receiving Family Benefits); and special drug programmes.

Nursing Home - A place in which accommodation is provided to persons requiring skilled nursing care, including persons convalescing from or being rehabilitated after illness or injury. Nursing homes in Nova Scotia provide Levels I and II care.

Palliative care - Involves active compassionate therapy for patients with terminal illness. The aim is to provide a pain free but alert condition, as well as social, psychological and spiritual support for patient and family.

Practice profile - An analysis of a physician's fees by procedure, for the purpose of examining reimbursement or practice patterns.

Primary Health Care - Primary Health Care is the first level of contact of the public with the health system. It includes treatment services as well as health promotion and disease prevention, all focused on the main health problems of the community. It provides services which are accessible and affordable, and is based on significant community participation.

Provincial Health Council (N.S.) - A forum for broad public participation in health planning and the establishment of Health Goals. The Council will provide general direction for the health system and advise Government on a wide range of health-related issues.

Rationalization (of services) - Increasing the efficiency of service delivery by promoting concentration of specialized services in a limited number of locations, eliminating unnecessary duplication of services in a defined area, etc.

Regionalization (of health planning and services) - Adapting a region's health services to the particular needs of the region, without decentralization of responsibility/authority.

Regional Health Agency - Advisory body that will examine the full range of health-related services in a given region, and provide recommendations to the Minister of Health regarding the planning and management of those services.

Regional Rehabilitation Centre - Facility intended to provide the most intensive level of rehabilitation for persons discharged from psychiatric services who have the potential to move on to less restrictive alternatives in the community.

Respite care - Patient care provided intermittently in the home or institution in order to provide temporary relief to the family who is providing continuous care to the patient in the home.

Supportive care - Care intended to provide support rather than cure or rehabilitation - e.g. palliative care and respite care.